

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON						c. LENGTH OF STAY IN 1b 18 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OXFORD					
3. NAME OF DECEASED (Type or print) First JESSIE Middle Graham Last ADKINS						4. DATE OF DEATH Month 2 Day 9 Year 1966					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 3, 1882		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State, or foreign country) KENT COUNTY, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER R. GRAHAM						14. MOTHER'S MAIDEN NAME SARAH SMITH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-44500		17. INFORMANT Miss Mary Adams		Address Oxford, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, aspiration, RLL 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4th	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fractured left hip.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) Fell at home 22 pm 66							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8 p.m. 22 pm 19 66				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Oxford Maryland			
21. I certify that (I) (this hospital) attended the deceased from 22 pm , 19 66 , to 9 Feb , 19 66 , that (I) (we) last saw the deceased alive on 9 Feb , 19 66 , and that death occurred at 6 PM , from the causes and on the date stated above.											
22a. SIGNATURE Thurston Harrison						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10 Feb 66			
22c. PHYSICIAN'S NAME (Type) THURSTON HARRISON						22d. ADDRESS Crofton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb 12, 66		23c. NAME OF CEMETERY OR CREMATORY Parson		23d. LOCATION (City, town or county) (State) Salisbury Md			
24. FUNERAL DIRECTOR Bill Back						ADDRESS Crofton, Md		25a. REC'D BY REGISTRAR DATE FEB 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN 1b 3 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Easton					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hurlock 09-2 d. STREET ADDRESS Taylor Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Steven Elwood Andrews			4. DATE OF DEATH February 23 19 66		5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 14, 1881			9. AGE (In years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (County & State, or foreign country) Hurlock, Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Joseph Benson Andrews			14. MOTHER'S MAIDEN NAME Mary Todd			15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) Sp - Am		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Mr. Phipp S. Andrews, Hurlock, Maryland			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4211 Congestive heart failure DUE TO (b) Calcific aortic stenosis DUE TO (c) Hypostatic pneumonia			INTERVAL BETWEEN ONSET AND DEATH Uncertain		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (II) (we) last saw the deceased alive on 19 , and that death occurred at 6:30 M. from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 6:30 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hurlock (County) (State)		22a. SIGNATURE Robert W. Trever M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Robert W. Trever, M.D.			22d. ADDRESS Easton, Maryland			22b. DATE SIGNED 2-23-66			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
23b. DATE THEREOF Feb 26, 1966			23c. NAME OF CEMETERY OR CREMATORY Unity Washington Cemetery			23d. LOCATION (City, town or county) Hurlock, Maryland			24. FUNERAL DIRECTOR Complete Funeral Service, Cambridge, Md.		
25a. REC'D BY REGISTRAR MAR 1 1966			25b. REGISTRAR'S SIGNATURE J. Charles Judge			25c. REGISTRAR'S ADDRESS			25d. REGISTRAR'S PHONE NO.		

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>												
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN ID		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE				17-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ALICE Middle MARY Last BAILEY						4. DATE OF DEATH Month 2 Day 7 Year 1966						
5. SEX F		6. COLOR OR RACE COI		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 13, 1895		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY SEA FOOD		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ISSAC NIXON						14. MOTHER'S MAIDEN NAME ROSE TURNER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rectal hemorrhage 5723 DUE TO (b) Ulcer colitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 days (?)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute malnutrition												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5 Feb</u>, 19<u>66</u>, to <u>7 Feb</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>7 Feb</u>, 19<u>66</u>, and that death occurred at <u>10 p.m.</u> from the causes and on the date stated above.												
22a. SIGNATURE Thornton Harrison						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 8 Feb 66			
22c. PHYSICIAN'S NAME (Type) THORSTON HARRISON						22d. ADDRESS Easton Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)						
Burial		2-17-66		Baths Creek Cem.		Stevensville Md						
24. FUNERAL DIRECTOR James B Doshier						ADDRESS Easton md		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE John L. Judge		



FOR STATE
HEALTH DEPT.

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02859

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02834

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Trappe		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton	
c. LENGTH OF STAY IN ID 9 years		d. STREET ADDRESS Aurora Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Marshall's Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henrietta Bartlett		4. DATE OF DEATH 2/10/1966	
SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/3/1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 94 yrs.
11. BIRTHPLACE (State or foreign country) Talbot Co Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unkn.		14. MOTHER'S MAIDEN NAME Henrietta Kirby	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Maggie Willey, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Snarition (60# ±) 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Age + lack of appetite DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fract hip - 2-3 weeks ago		INTERVAL BETWEEN ONSET AND DEATH Months	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis D. Skety		22. DATE SIGNED 2-11-66	
EXAMINER'S NAME (Type) WELTY JR		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/12/1966	23c. NAME OF CEMETERY OR CREMATORY Spring Hill	23d. LOCATION (City, town or county) (State) Easton, Md.
24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md.		25a. REC'D BY REGISTRAR FEB 14 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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Handwritten notes and signatures, including a large signature in the center.

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1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i> c. LENGTH OF STAY IN ID <i>17 hrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Kentucky</i> b. COUNTY <i>Pike</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Justiceville (rural)</i> d. STREET ADDRESS <i>RFD</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>James Monroe Blevins</i> 5. SEX <i>male</i> 6. COLOR OR RACE <i>white</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>4/6/1890</i> 9. AGE (In years last birthday) <i>75</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					4. DATE OF DEATH <i>2 - 10 - 19 66</i> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Miner</i> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <i>Pike Kentucky</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> 				
13. FATHER'S NAME <i>Matt Blevins</i> 14. MOTHER'S MAIDEN NAME <i>Sarah Mullins</i> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <i>unkn.</i> 17. INFORMANT <i>Mrs. James M. Blevins, Ridgley, Md.</i> Address					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200 Congestive heart failure</i> DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>Uncertain</i>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 5:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Robert W. Trever</i> 22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i> 22d. ADDRESS <i>Easton, Maryland</i> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>2/12/1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Johnson Memorial Park</i>		23d. LOCATION (City, town or county) (State) <i>Pikeville, Ky.</i>		
24. FUNERAL DIRECTOR <i>Maurice E. Newnam & Son</i> Address <i>Easton, Md.</i>					25a. REC'D BY REGISTRAR <i>FEB 15 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

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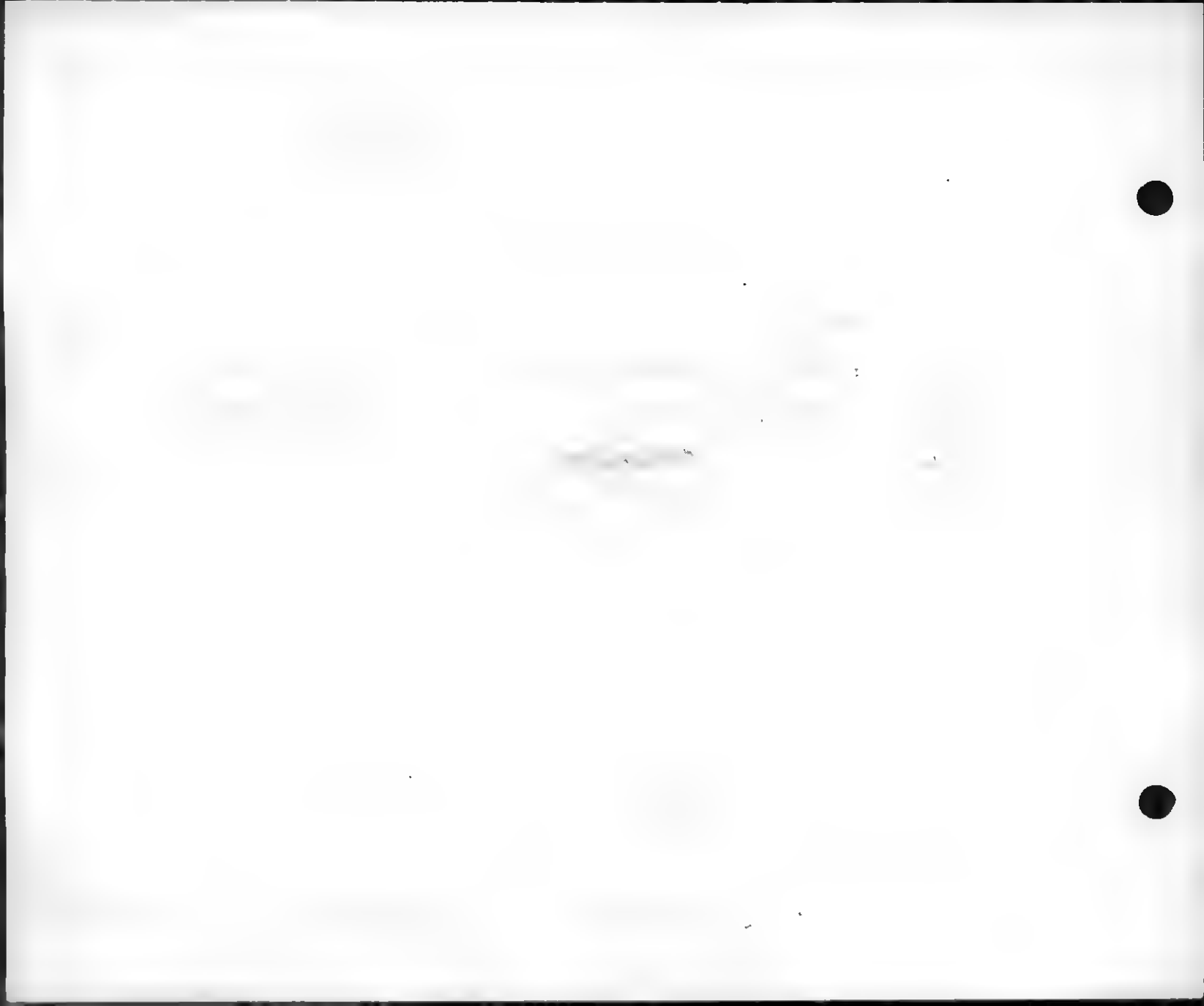
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07836

1 PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN 1b <u>11 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Memorial Hospital</u>		e STREET ADDRESS <u>Rural-Federalburg</u>	
3 NAME OF DECEASED (Type or print) <u>James Edward Brummell</u>		4 DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1966</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>47</u> F UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUS DRIVER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11 BIRTHPLACE (State or foreign country) <u>CAROLINE Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Fred Brummell</u>		14 MOTHER'S M maiden name <u>HARRIETT McGEE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>213-44-6486</u>	
17 INFORMANT <u>James B. Dashell</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Surgical shock + anesthesia</u> DUE TO (b) <u>Laminectomy + mental apprehension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>"Went back" on operating table</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James B. Dashell</u> M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED <u>2-19-66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, or REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>2-22-66</u>	<u>Federalburg Cemetery</u>	<u>Federalburg Caroline Md.</u>
24. FUNERAL DIRECTOR <u>James B. Dashell Easton Md</u>		25a REC'D BY REGISTRAR DATE <u>FEB 24 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

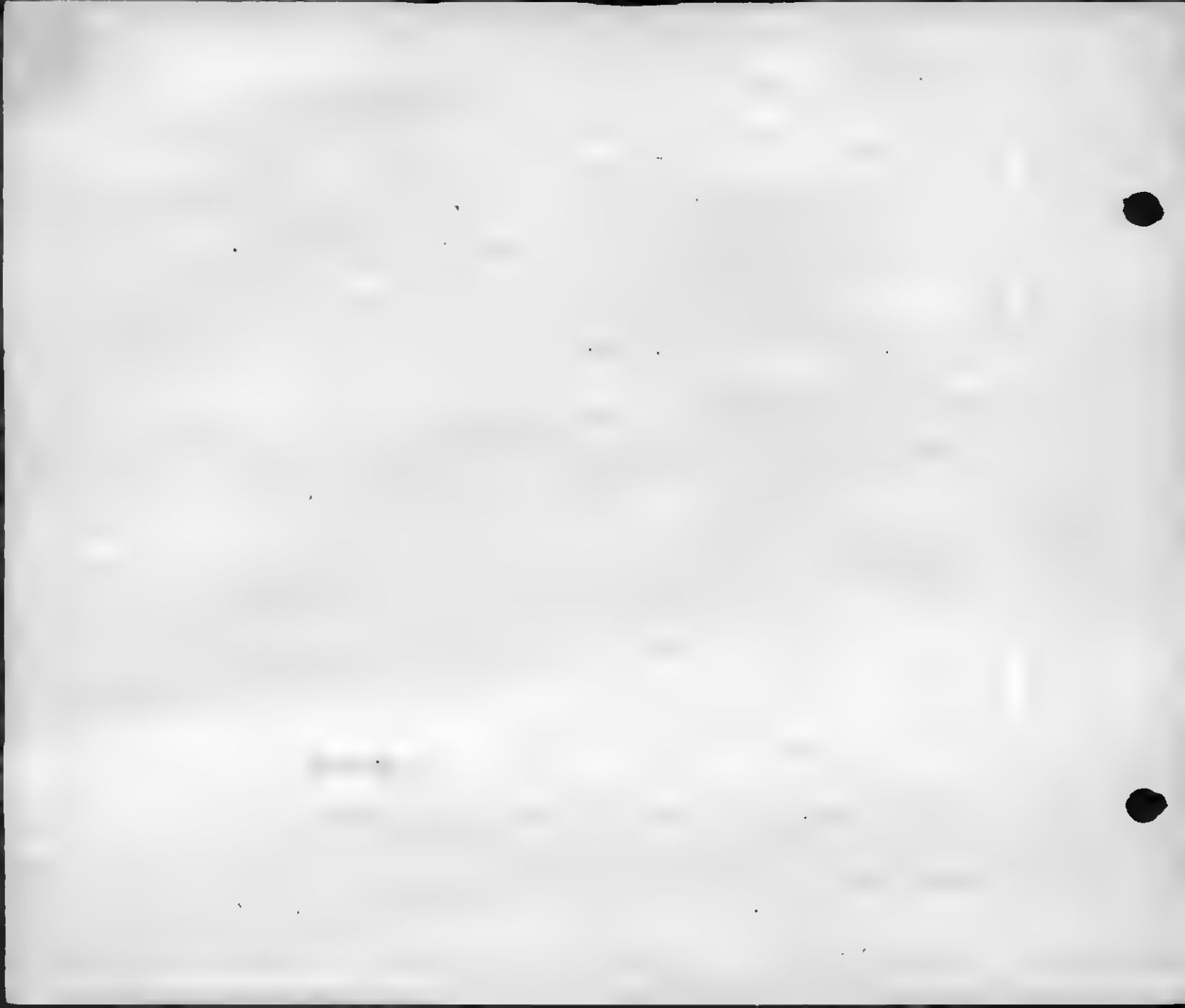
CERTIFICATE OF DEATH

02862

02862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN IL <u>32 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOUSE IN THE PINES - EASTON</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> d. STREET ADDRESS <u>Box 3 - Box 95 209 BROOKLETTS</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HERALD</u> First <u>GILBERT</u> Middle <u>CALLAHAN</u> Last				4. DATE OF DEATH <u>Feb.</u> <u>28</u> Day <u>19</u> Year <u>66</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 25, 1895</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MANAGER ABBOTT'S DAIRY TALBOT COUNTY, MD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>CHARLES A. CALLAHAN</u>			
14. MOTHER'S MAIDEN NAME <u>SUSAN HOPKINS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>212-03-0737</u>				17. INFORMANT <u>MRS. CALLAHAN</u> Address <u>EASTON - MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Parkinsonism</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from..... 19..... to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... 6:05 PM..... from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Trever</u> M.D.				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>MARCH 2, 1966</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		23d. LOCATION (City, town or county) <u>EASTON - MD.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> Address <u>[Address]</u>				25a. REC'D BY REGISTRAR <u>MAR 2 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

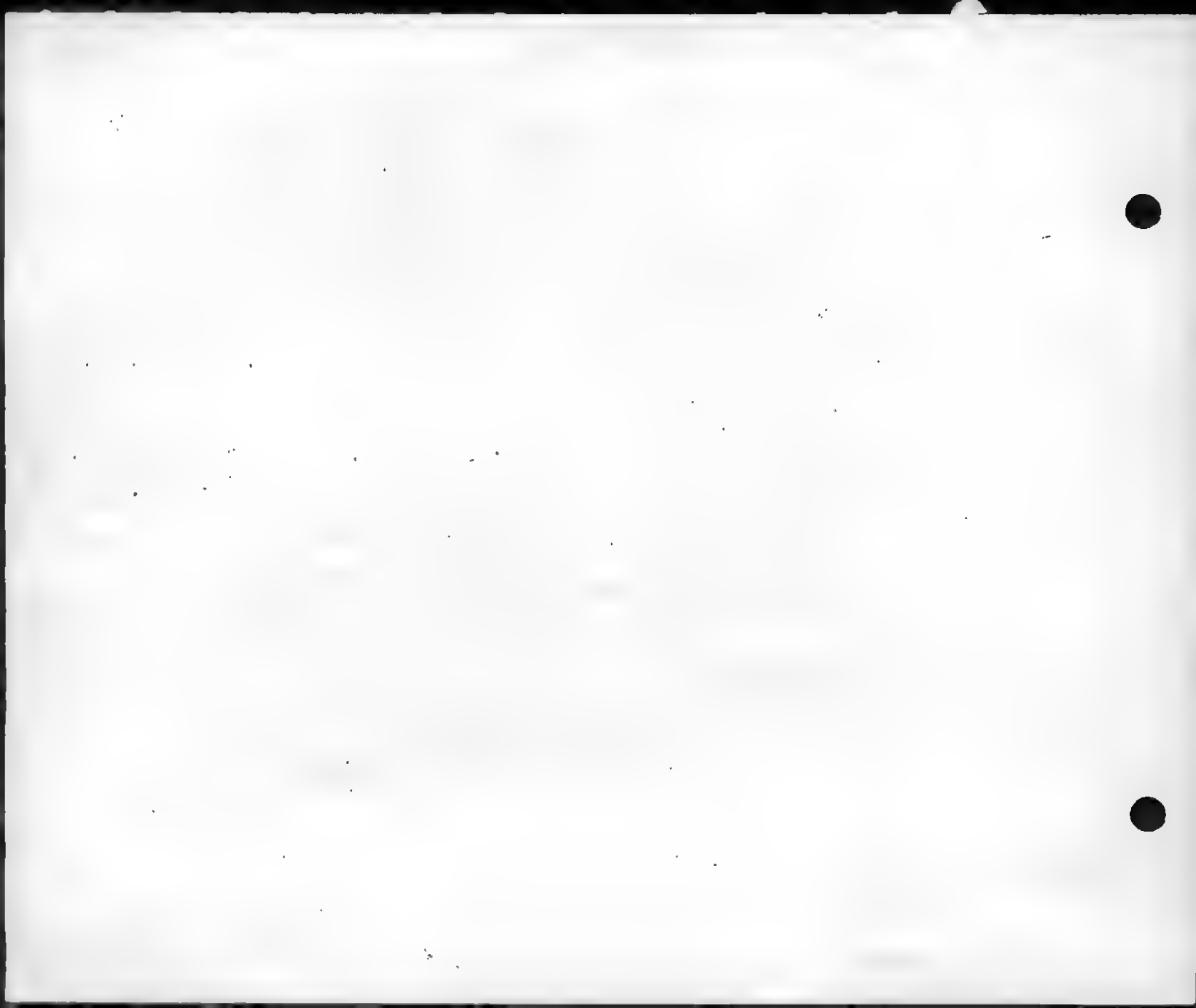


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
c. LENGTH OF STAY IN 1b <u>10 min.</u>		d. STREET ADDRESS <u>Newton Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Clayton</u> Last <u>Carroll</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>8</u> - Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 7, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Caroline County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>L. Clayton Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Sallie E. Poole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>12</u>	
17. INFORMANT <u>Mrs. Martha E. Cook, Federal Bur., Md.</u>		Address <u>Federal Bur., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation, Right ventricular Dilatation</u> Interval between onset and death <u>minutes</u> (b) <u>Chronic Obstructive Emphysema</u> <u>25yrs</u> (c) <u>Intrinsic and extrinsic Bronchial Asthma</u> <u>life</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> , 19 <u>66</u> , to <u>2/8/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/8/66</u> , 19 <u>66</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold B. Plummer</u>		22b. DATE SIGNED <u>2/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer</u>		22d. ADDRESS <u>Preston Mary; and</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Junior Order Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Preston, Maryland</u>
24. FUNERAL DIRECTOR <u>Trampten Funeral Home Federal City, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



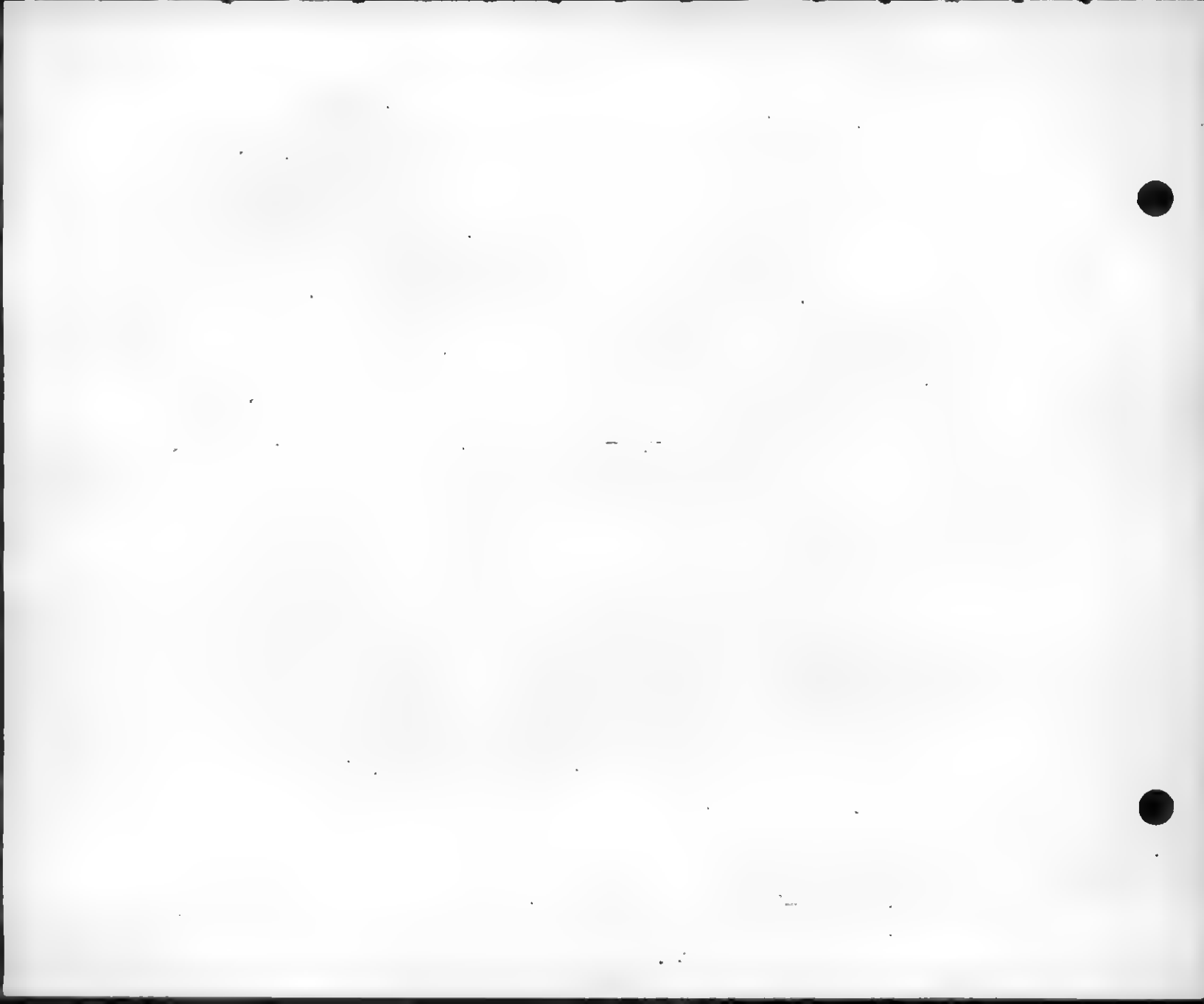
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02864

02839

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural</u> c. LENGTH OF STAY IN ID <u>8 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Funerary</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Greensboro</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edward Carter</u> First <u>Edward</u> Middle <u>Carter</u> Last <u>Carter</u>				4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-18-1898</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Carter</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Satterfield</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) _____				16. SOCIAL SECURITY NO. <u>220-34-9260</u>		17. INFORMANT Address <u>Agnes Carter Greensboro, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <u>< 2 wks.</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED , (Enter nature of injury in Part I or Part II of Item 18.) _____					
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>Feb 5</u> 19<u>66</u>, and that death occurred at <u>7:40</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert W. Trever</u>						22b. DATE SIGNED _____ M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) _____						22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		23d. LOCATION (City, town or county) (State) <u>Greensboro, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>J. E. Boulais, Greensboro, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>FEB 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO REGISTER OR AMENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



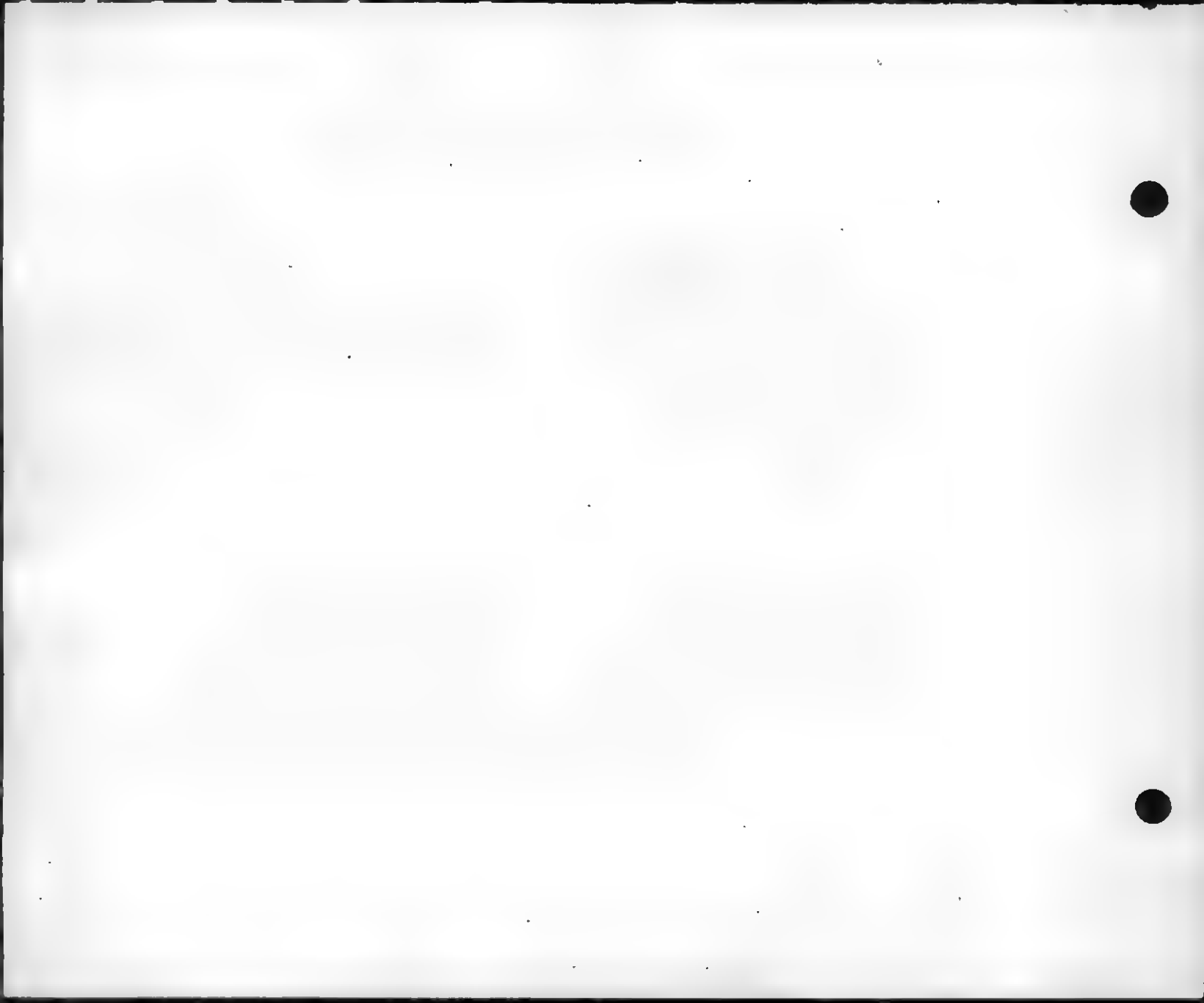
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, within any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>3 days - 4 1/2 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>	
3. NAME OF DECEASED (Type or print) <u>Eliya Beth Coursey</u>		d. STREET ADDRESS	
5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>Feb. 1</u> 19 <u>66</u>	
8. DATE OF BIRTH <u>Apr. 13, 1916</u> 49 yrs.		9. AGE (in years last birthday) <u>49</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>Talbot, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CLARENCE BROWN</u>		14. MOTHER'S MAIDEN NAME <u>TINA BENSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William H. Coursey</u> Address <u>Rt. 2, Easton Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis P. Welty</u> M.D.		22. DATE SIGNED <u>2-5-66</u>	
EXAMINER'S NAME (Type) <u>WELTY</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-7-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Richards Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Easton Md.</u>	
24. FUNERAL DIRECTOR <u>James B. Washwell</u> Address <u>Easton Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 8 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>James B. Washwell</u>	



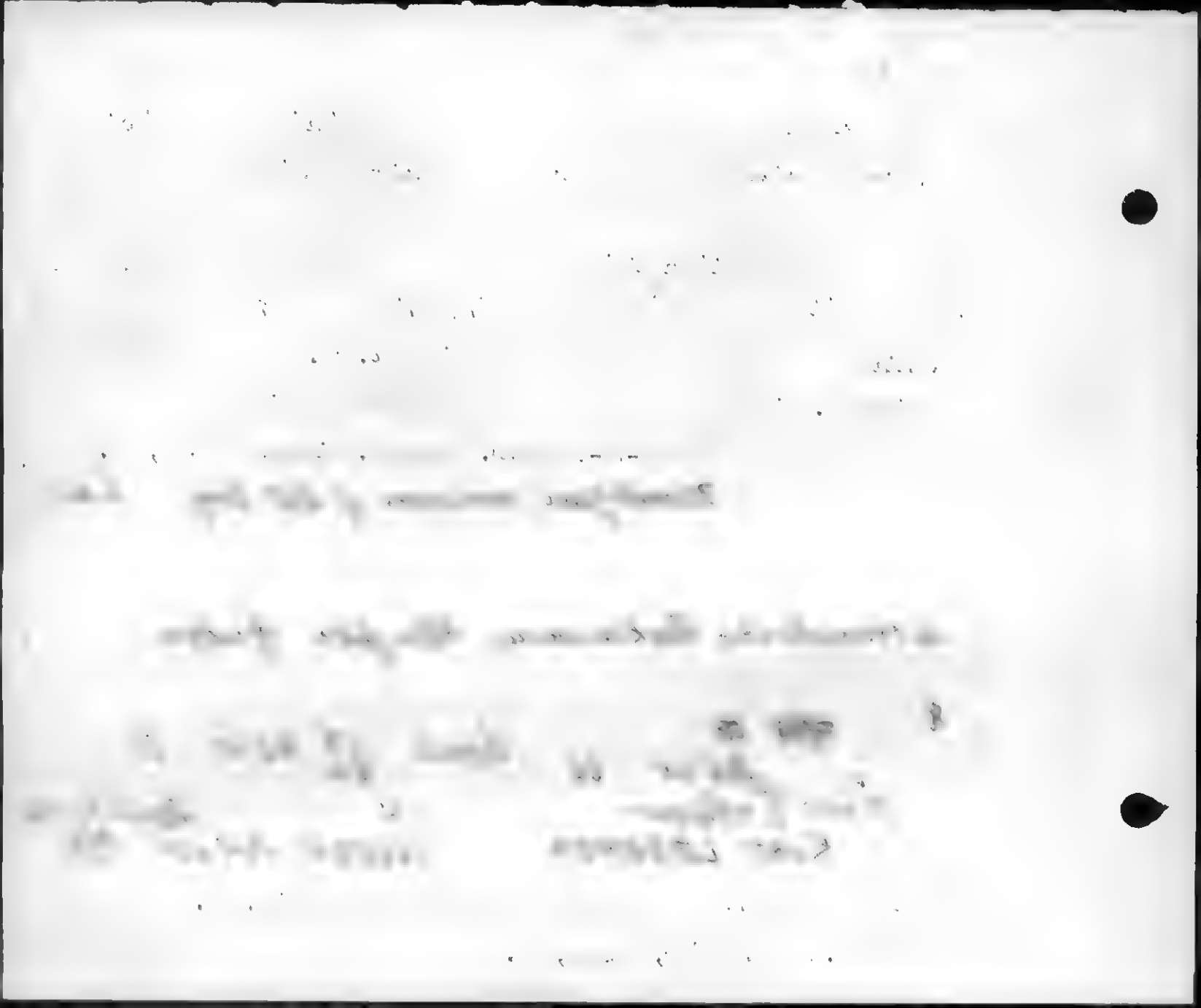
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (rural) Easton		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) George Wilson Fisher		4. DATE OF DEATH Month 2 Day 28 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/1914
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Tioga Co. Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matthew W. Fisher		14. MOTHER'S MAIDEN NAME Gentruide Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-12-3982	
17. INFORMANT Mrs. George W. Fisher, Cordova, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchogenic carcinoma of left lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis Parkinsonism, Rheumatoid Arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 1966 to Feb 28 1966 , that (I) (we) last saw the deceased alive on Feb 28 1966 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Kurt Lederer		22b. DATE SIGNED March 1, 1966	
22c. PHYSICIAN'S NAME (Type) KURT LEDERER		22d. ADDRESS QUEEN ANNE MD.	
23a. BURIAL, CREMATION, Removal (Specify) Burial	23b. DATE THEREOF 3/3/1966	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park	23d. LOCATION (City, town or county) (State) Easton, Md.
24. FUNERAL DIRECTOR MAURICE E. NEWMAN & SON, Easton, Md.		25a. REC'D BY REGISTRAR DATE 3 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02867											
02843											
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>QUEEN ANNE'S</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>6 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL QUEEN ANNE</i>				d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Edward</i> Last <i>Foster</i>						4. DATE OF DEATH Month <i>2</i> Day <i>24</i> Year <i>1966</i>					
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 6, 1886</i>		9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED PAINTER</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>CONTRACTOR</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Wye Mills D.A. Co., Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph S. Foster</i>						14. MOTHER'S MAIDEN NAME <i>ANNIE WARNER</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>213-24-1412</i>		17. INFORMANT <i>Mrs. Mary M. Foster</i> Address <i>RURAL QUEEN ANNE, MARYLAND</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spontaneous hemorrhage</i> DUE TO (b) <i>Carcinoma of the stomach</i> DUE TO (c) <i>Arteriosclerosis pulmonary</i>										INTERVAL BETWEEN ONSET AND DEATH <i>1 DAY</i> <i>2 YRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis pulmonary</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>2-24</i> , 19 <i>66</i> , to <i>2-24</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2-24</i> , 19 <i>66</i> , and that death occurred at <i>6 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Stephen p. Carney</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2-25-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Stephen p. Carney</i>						22d. ADDRESS <i>Easton, Maryland</i> <i>2/25/66</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>FEB. 28, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CHESTERFIELD CEMETERY</i>				23d. LOCATION (City, town or county) (State) <i>CENTREVILLE, MARYLAND</i>	
24. FUNERAL DIRECTOR <i>James H. Bunting, Jr., Barton Bros., Centerville, Md.</i>						25a. RECEIVED BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

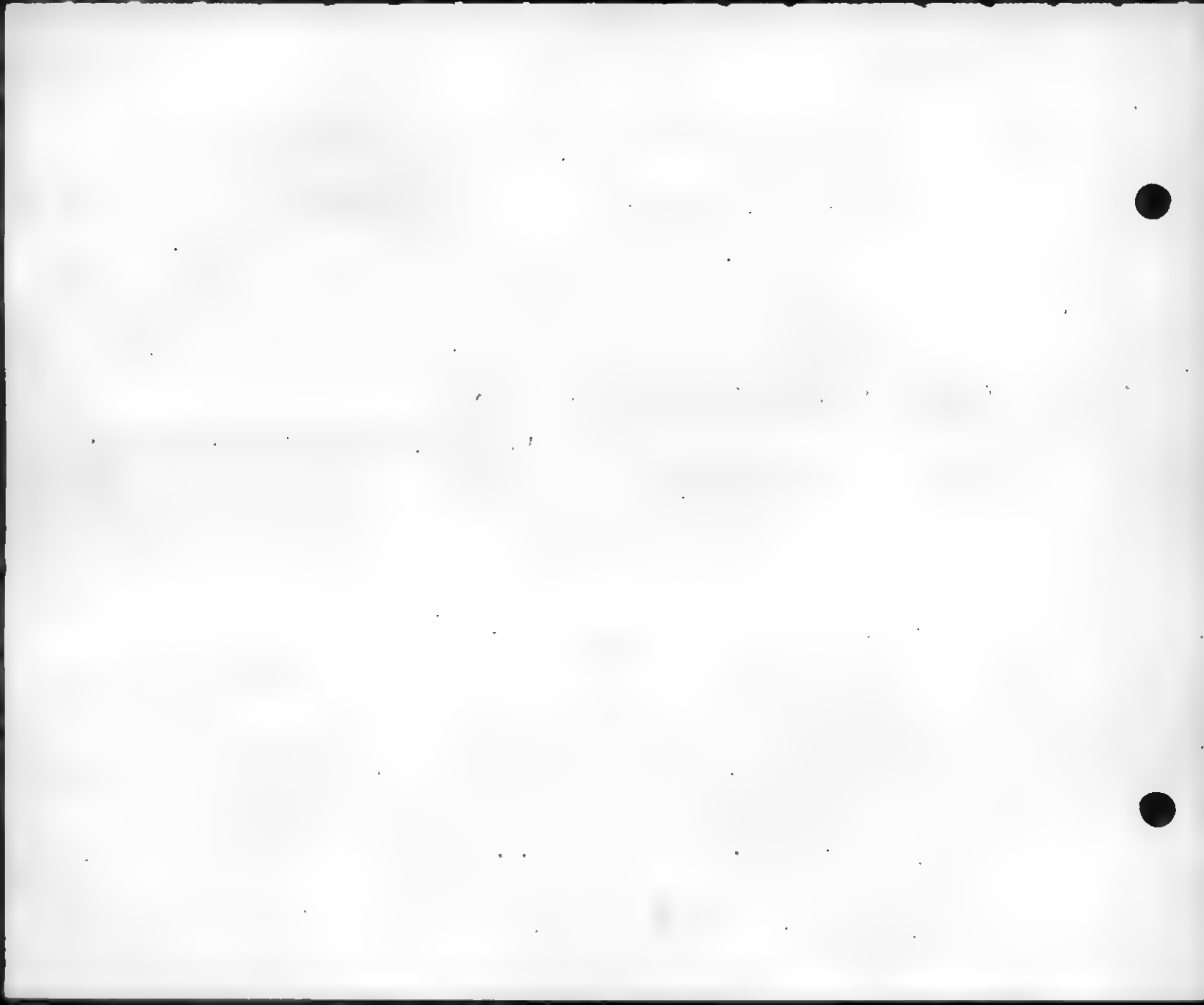
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> d. STREET ADDRESS <u>203 DEVER ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Goldsbrough</u> Middle <u></u> Last <u></u> 4. DATE OF DEATH <u>Feb</u> <u>16</u> <u>1966</u>			5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>MARCH 21, 1893</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 2 YEAR <u>10</u> Months <u>26</u> Days IF UNDER 24 HRS. <u></u> Hours <u></u> Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT - MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>FRANCIS CARROLL GOLDSBOROUGH</u> 14. MOTHER'S MAIDEN NAME <u>MARY HILL</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>MRS. MALCOLM DATES</u> Address <u>BALTIMORE, MD.</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> (b) <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post-polio myelitic Kyphoscoliotic cardiopulmonary disease</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u></u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State) <u></u>						
21. I certify that I (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that I (we) last saw the deceased alive on <u>Feb 16, 1966</u> , and that death occurred at <u>10:15</u> P.M. , from the causes and on the date stated above.					22a. SIGNATURE <u>Robert W. Trever</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1/17/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u> M.D. 22d. ADDRESS <u>Easton, Maryland</u> <u>1/17/66</u>					23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>FEBRUARY 19, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SPRINGHILL CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>EASTON - MARYLAND</u>				
24. FUNERAL DIRECTOR <u>Easton Md</u> 25a. REC'D BY REGISTRAR <u>FEB 21 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton (rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton (rural)</u>	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Percy Alton</u> Middle <u>Gregory</u> Last <u></u>		4. DATE OF DEATH Month <u>2/8</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1902</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bridge operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James P. Gregory</u>		14. MOTHER'S MAIDEN NAME <u>Clara Lomax</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-8207</u>	
17. INFORMANT <u>Mrs. P. Alton Gregory, Easton, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u> <u>several years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 23, 1963</u> to <u>Feb. 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 8, 1966</u> , and that death occurred at <u>8:41</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dale R Kollman</u> M.D.		22b. DATE SIGNED <u>Feb. 8, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dale R Kollman, MD</u>		22d. ADDRESS <u>12 N. Hanson St.; Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/10/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR <u>MURICE E. NEWMAN & SON, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

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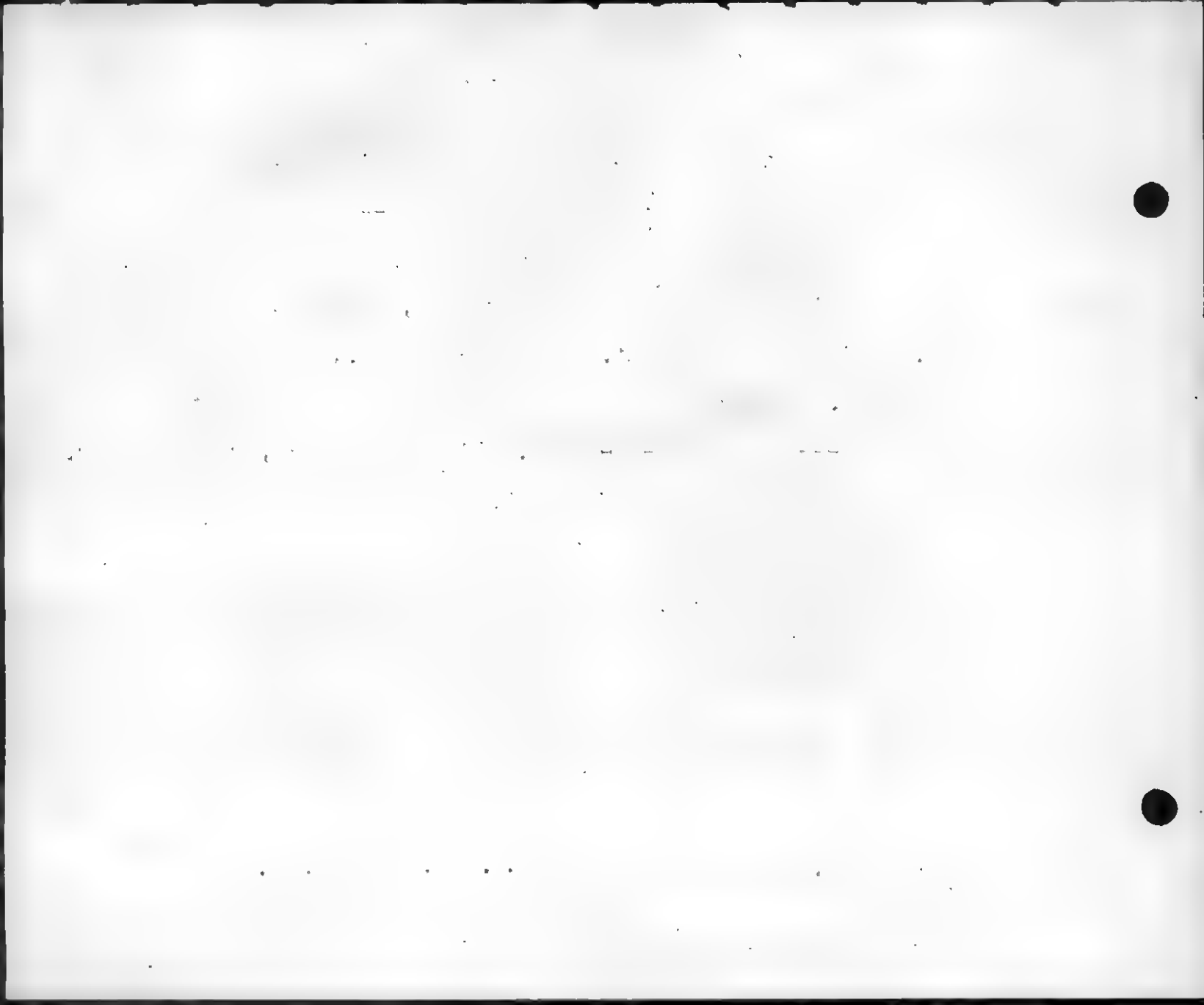
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>13 hours</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i>		d. STREET ADDRESS <i>---</i>	
3. NAME OF DECEASED (Type or print) <i>Mr Paul E. Haddaway</i>		4. DATE OF DEATH <i>2. 27 1966</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 23, 1897</i>	
9. AGE (In years last birthday) <i>68</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maint.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Co., Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>James E. Haddaway</i>	
14. MOTHER'S MAIDEN NAME <i>Annie May Bassett</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-06590</i>		17. INFORMANT <i>Clifton Haddaway, Tilghman, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Community Acquired Pneumonia</i>		DUE TO (b) <i>Cerebral Edema, Heart Dis</i>		DUE TO (c) <i>Diabetic Nephrosis</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>7 yr</i>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>26 Feb, 1966</i> to <i>27 Feb, 1966</i> that (I) (we) last saw the deceased alive on <i>26 Feb, 1966</i> and that death occurred at <i>12:45</i> M, from the causes and on the date stated above.	
22a. SIGNATURE <i>R. Lane Wroth</i>		22b. DATE SIGNED <i>2-28-66</i>		22c. PHYSICIAN'S NAME (Type) <i>R. Lane Wroth</i>		22d. ADDRESS <i>M.D. St. Michaels, Md.</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-2-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Tilghman Cemetery</i>		23d. LOCATION (City, town or county) <i>Tilghman Md</i>		23e. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR <i>Hamberton Harrison, St. Michaels, Md.</i>		25a. REC'D BY REGISTRAR <i>DATE MAR 2 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

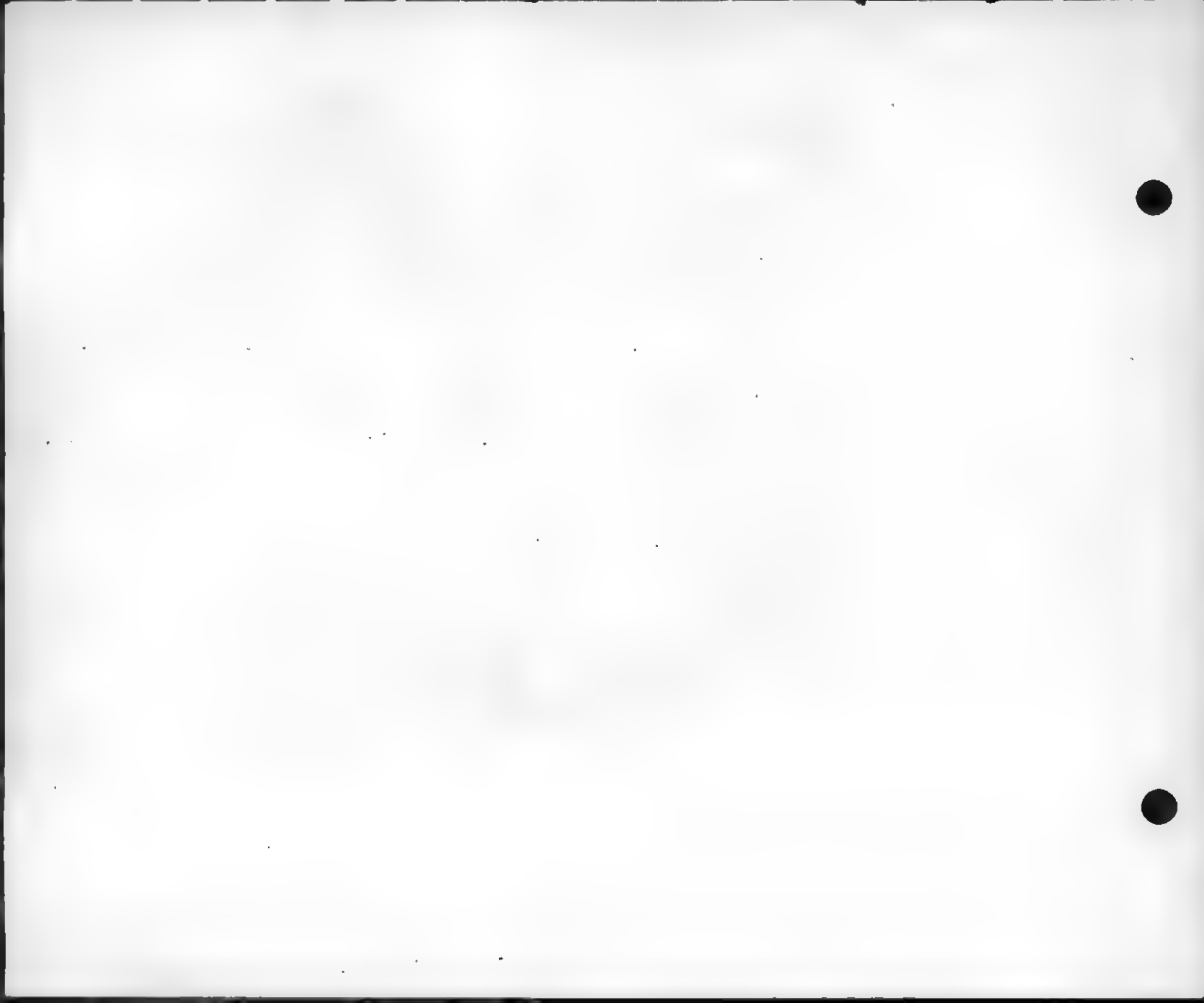


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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> d. STREET ADDRESS <u>CR-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Mr. FRANK BENJAMIN HANDY</u> First Middle Last 4. DATE OF DEATH <u>2</u> <u>14</u> <u>1966</u> Month Day Year					5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 21, 1910</u> 9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Caroline County, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>William R. Handy</u> 14. MOTHER'S MAIDEN NAME <u>Sallie Russell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>5</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Ollie Tinker, Gettysburg, Dela. P.F.D.</u> Address					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure & pneumonia</u> DUE TO (b) <u>Cor Pulmonale</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>8 Feb</u> , 19 <u>66</u> , to <u>14 Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>14 Feb</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Thurston Harrison</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>15 Feb 66</u>					22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u> 22d. ADDRESS <u>Easton, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-17-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u> 23d. LOCATION (City, town or county) (State) <u>Federalburg, Maryland</u>					24. FUNERAL DIRECTOR <u>Frampton Funeral Home Federalburg</u> ADDRESS <u>Federalburg, Md.</u> 25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

FEB 18 1966



FOR STATE
HEALTH DEPT.

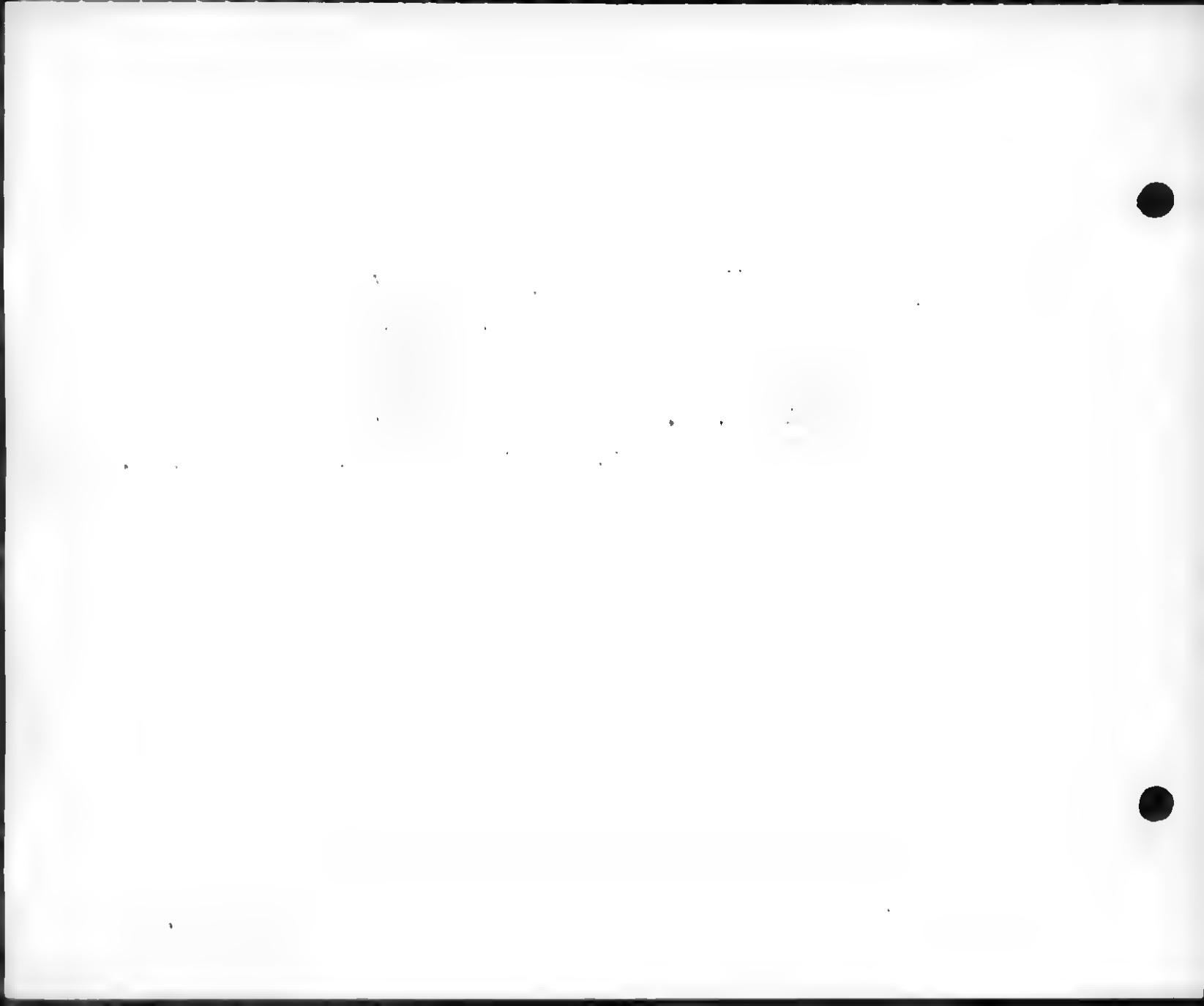
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Talbot	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c LENGTH OF STAY IN 1b 45m.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d STREET ADDRESS 412 Goldsboro Street	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY HARRINGTON JR.		4. DATE Month Feb Day 20 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/1913
9. AGE (In years last birthday) yrs 52		10. UNDER 1 YEAR Months 1 Days 20 Hours 19 Min 66	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Harrington, Sr.		14. MOTHER'S MAIDEN NAME Lucy Chance	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 212-10-7947	
17. INFORMANT Miss Lola Harrington, Easton, Md.		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 10 AM 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis O. Kelly M.D.		22. DATE SIGNED 2-20-66	
EXAMINER'S NAME (Type) KELTY JR		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 2/22/1966	
23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery		23d. LOCATION (City or town) (County) (State) Greensboro, Md.	
24. FUNERAL DIRECTOR Maurice E. Newnam-Jones		25a. REC'D BY REGISTRAR FEB 24 1966	
ADDRESS Easton, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO NOTARIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

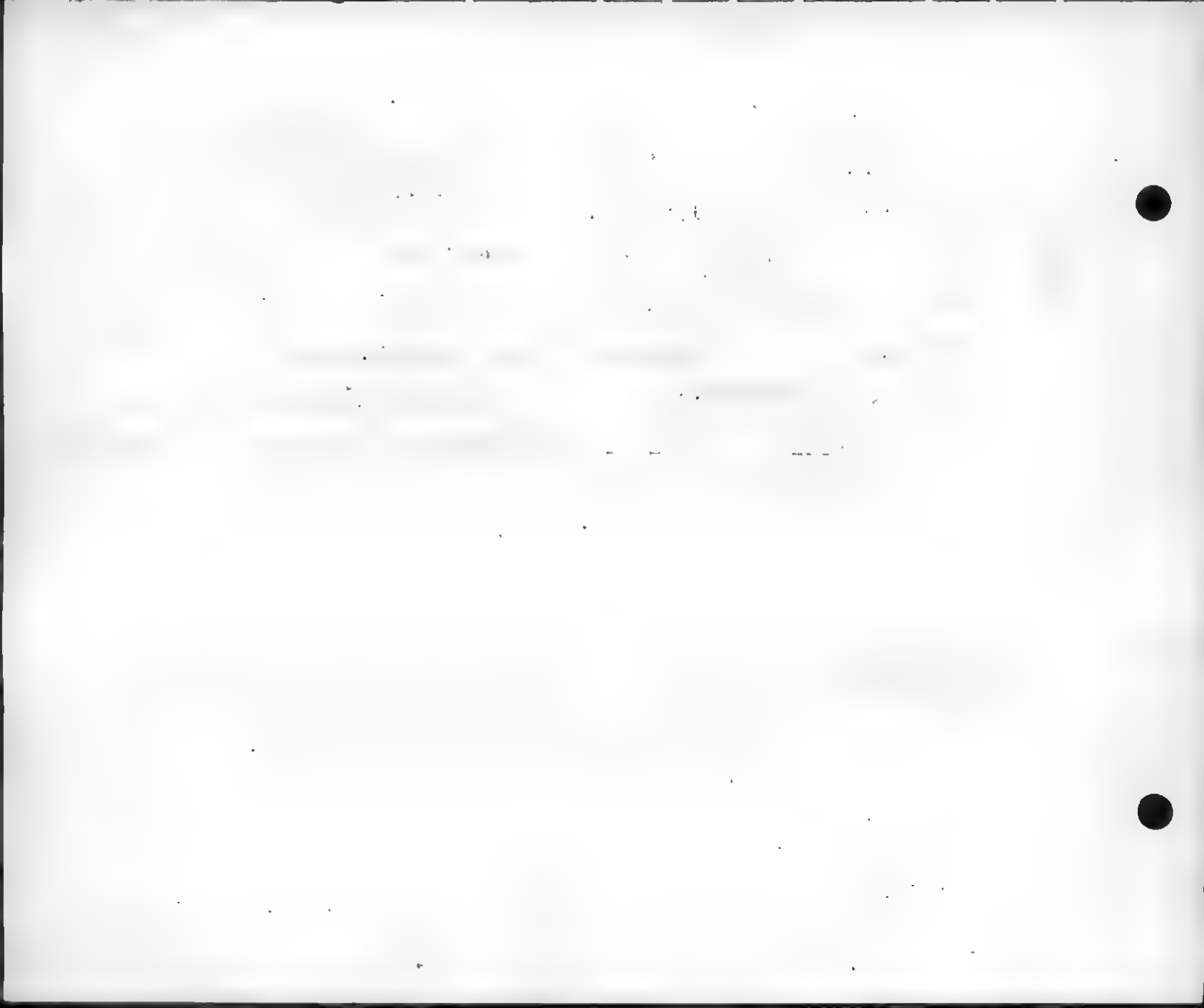
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02873		02850	
1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SHERWOOD d. STREET ADDRESS RURAL e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Warner HARRISON		4. DATE OF DEATH Month Feb Day 11 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 27, 1880
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY GENERAL STORE	
11. BIRTHPLACE (County & State, or foreign country) SHERWOOD MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN T. HARRISON		14. MOTHER'S MAIDEN NAME AMELIA ANNE WARNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-5081	
17. INFORMANT Charm Harrison, Easton Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) left hemiplegia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 12 Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 31 Jan 66 , 19 66 , to 11 Feb , 19 66 , that (I) (we) last saw the deceased alive on 10 Feb , 19 66 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Thornton Harrison		22b. DATE SIGNED 11 Feb 66	
22c. PHYSICIAN'S NAME (Type) THORNTON HARRISON		22d. ADDRESS Easton Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2-14-1966	Sherwood Cemetery	Sherwood Md
24. FUNERAL DIRECTOR Thornton Harrison		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 15 1966	

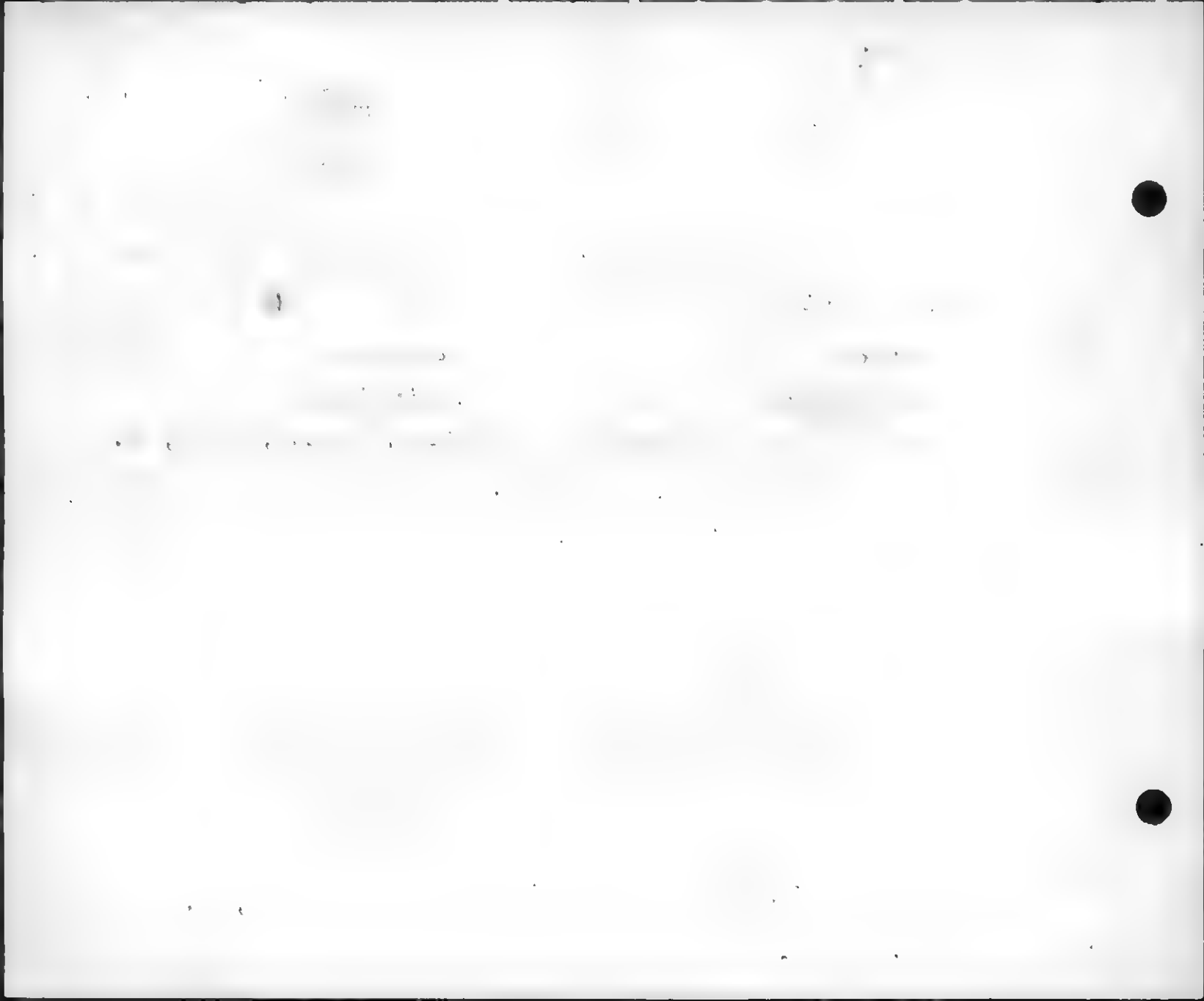


NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2 days 8 hrs</i>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>		d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>LAVINA</i> Last <i>Harrison</i>		4. DATE OF DEATH Month <i>2</i> - Day <i>10</i> Year <i>1966</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED	
8. DATE OF BIRTH <i>8/31/1919</i>		9. AGE (In years last birthday) <i>46</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Dorchester</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Albert Andrews</i>		14. MOTHER'S MAIDEN NAME <i>Addie Fitzhugh</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Daniel L. Harrison, Trappe, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mucoid plugging of the bronchial tree</i> DUE TO (b) <i>Acute purulent bronchitis</i> DUE TO (c) <i>Status asthmaticus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>6:30</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>Robert W. Trever</i>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input type="checkbox"/>		22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22h. ATTENDING PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (So classify)		23b. DATE THEREOF <i>2/12/1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City, town or county) (State) <i>Easton, Md.</i>		23e. REC'D BY REGISTRAR	
23f. REGISTRAR'S SIGNATURE <i>W. Maurice A. Newman, Son</i>		23g. ADDRESS <i>Easton, Md.</i>		23h. DATE <i>FEB 14 1966</i>		23i. REGISTRAR'S SIGNATURE <i>W. Judge</i>		23j. ADDRESS	



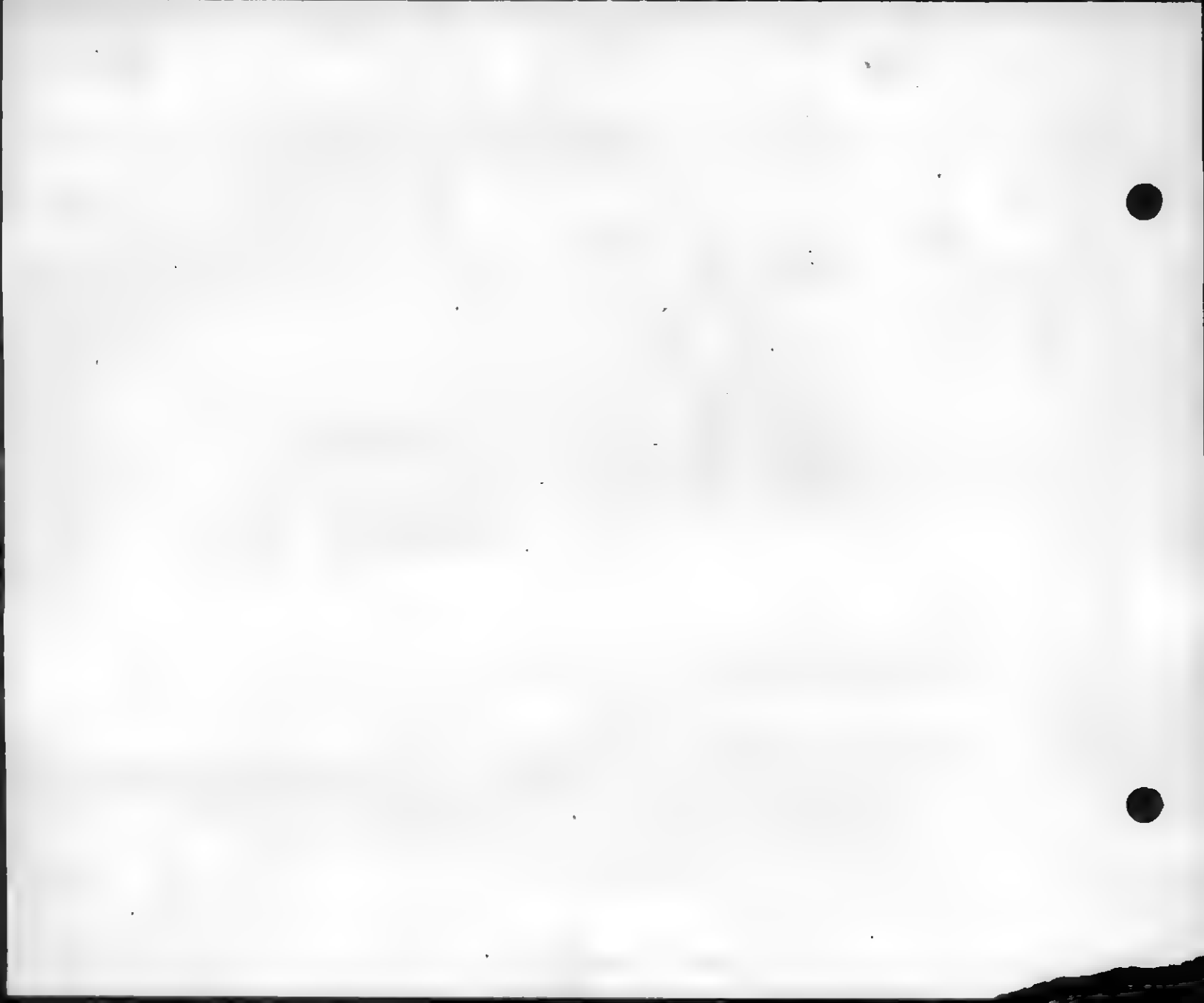
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> c. LENGTH OF STAY IN 1b <u>5yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Reo Vista Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bishop</u> d. STREET ADDRESS <u>RFD</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Samuel Howard</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>5</u> Year <u>1966</u>													
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1870</u>												
9. AGE (In years last birthday) <u>95</u> yrs. <table border="1" style="float: right; margin-top: -20px;"> <tr> <th colspan="3">IF UNDER 1 YEAR</th> <th colspan="3">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR			IF UNDER 24 HRS.			Months	Days	Hours	Min.			11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>	
IF UNDER 1 YEAR			IF UNDER 24 HRS.												
Months	Days	Hours	Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nat chmn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>													
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Howard</u>													
14. MOTHER'S MAIDEN NAME <u>Kathryn Selby</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes give war or dates of service) <u>XX</u>													
16. SOCIAL SECURITY NO. <u>156-12-7747</u>		17. INFORMANT <u>Horace Johnson Selbyville, Del.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cerebral Vascular Dis</u> DUE TO (c) <u>10y</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>40 hr</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Blindness</u>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 17, 1959</u> , to <u>Jan 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>3 Jan 1966</u> , and that death occurred at <u>1:00 P.</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>R. Paul C. Selby</u>		22b. DATE SIGNED <u>2-7-66</u>													
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/66</u>													
23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		23d. LOCATION (city, town or county) (State) <u>Bishopville, Md.</u>													
24. FUNERAL DIRECTOR <u>Edwin Whaley Selbyville, Del.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>													
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>															

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

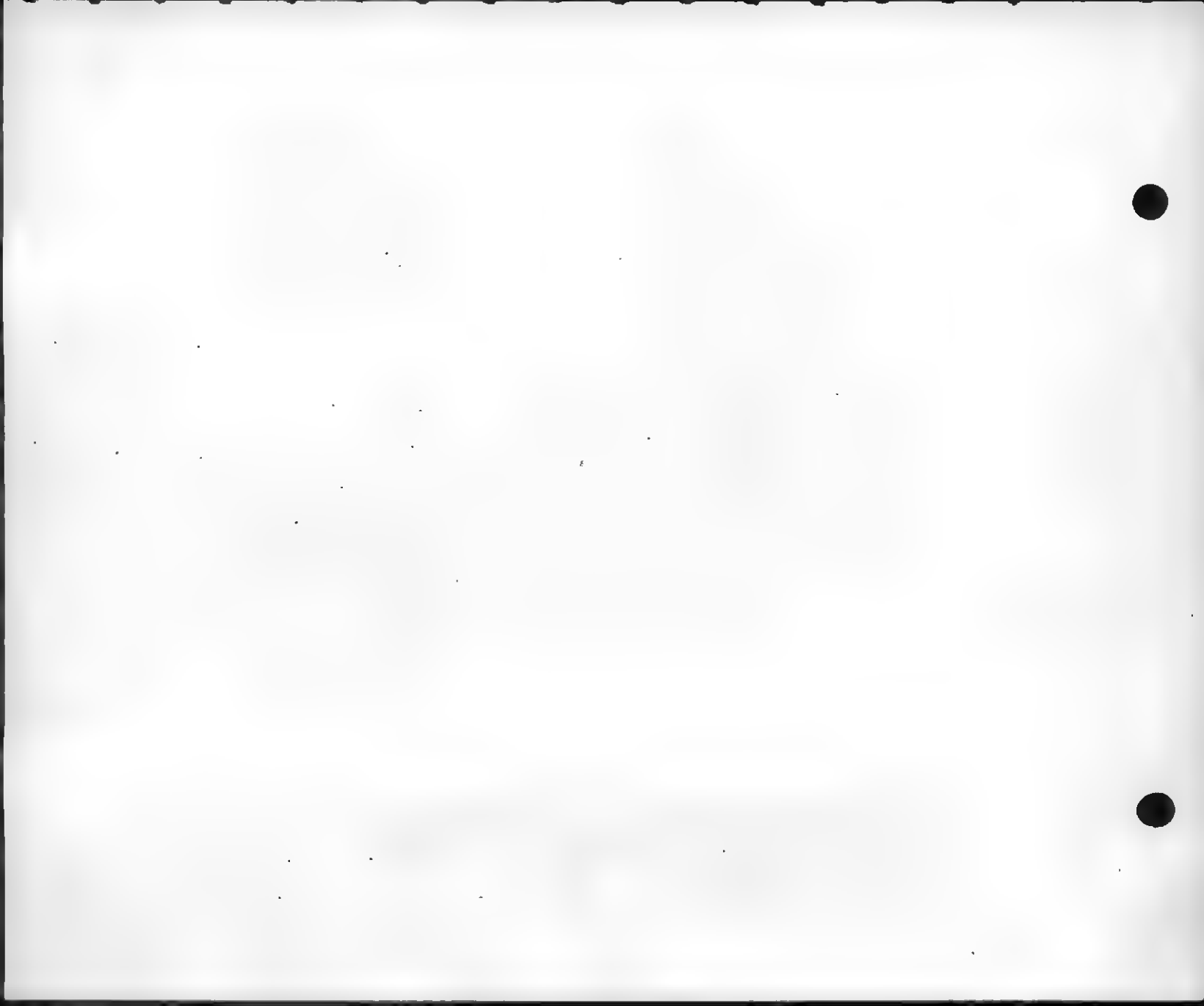
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02876

02853

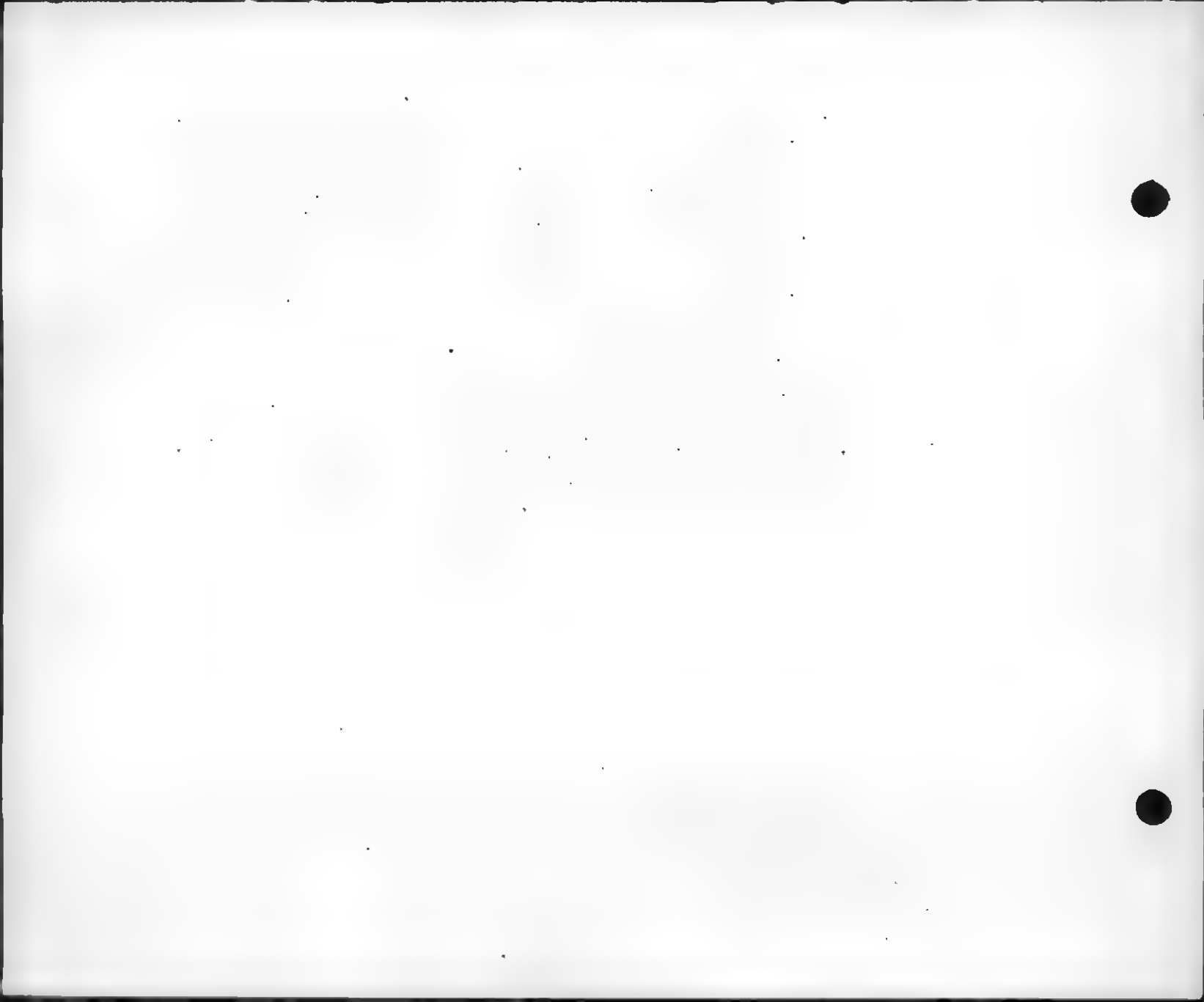
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>ADELINE</u> Last <u>HUXTER</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 9 - 1899</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>CHESTER MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CARROW HARRIS</u>		14. MOTHER'S MAIDEN NAME <u>WILHELMINA SEWARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-20-6874</u>	
17. INFORMANT <u>MRS. CHAS. FOWLER - WYEMILLS MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation.</u> DUE TO (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>< 1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>6 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED <u>2-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>		22d. ADDRESS <u>Easton Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>FEB. 17</u>	23c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>	23d. LOCATION (City, town or county) (State) <u>STEVENSVILLE MD.</u>
24. FUNERAL DIRECTOR <u>Edgar L. Saxe Per Orem Thompson</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>105 N. Liberty</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Kennard</u> Last <u>Lane</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Queenstown Q.A.C., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Lane</u>		14. MOTHER'S MAIDEN NAME <u>Annie Heavlow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>218-16-6224</u>	
17. INFORMANT <u>Mrs. Isabel B. Lane</u>		Address <u>Centreville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis - left hemiplegia</u> DUE TO (b) <u>Cerebral atherosclerosis</u> DUE TO (c) <u>(?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9 Feb</u> , 19 <u>66</u> , to <u>14 Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>14 Feb</u> , 19 <u>66</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. H. Harrison</u>		22b. DATE SIGNED <u>15 Feb 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. H. Harrison</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Feb. 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chestertown Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Centreville, Md.</u>
24. FUNERAL DIRECTOR <u>James H. Batten Jr., Batten Bur. Centreville, Md.</u>		25a. REC'D BY REGISTRAR <u>2nd. Jules Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>FEB 17 1966</u>	



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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02878					02856				
1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALSTON c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXFORD d. STREET ADDRESS MORRIS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First EDWARD Middle LLOYD Last LLOYD			4. DATE OF DEATH Month 2 Day 27 Year 1966						
5. SEX M		6. COLOR OR RACE WE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/16/1891		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months 8 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10b. KIND OF BUSINESS OR INDUSTRY BANKING			11. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD LLOYD					14. MOTHER'S MAIDEN NAME ELIZABETH ROBINSON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. 011-10-5689		17. INFORMANT MRS. LLOYD Address OXFORD - MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Myocardial infarction due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic coronary thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 25 Feb , 19 66 , to 27 Feb , 19 66 , that (I) (we) last saw the deceased alive on 27 Feb , 19 66 , and that death occurred at 11:30 M, from the causes and on the date stated above. 22a. SIGNATURE Thorsten Harrison M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 28 Feb 66 22c. PHYSICIAN'S NAME (Type) THORSTEN HARRISON 22d. ADDRESS Ches. Bay Land									
23a. BURIAL (CREMATION) REMOVAL (specify) BURIAL			23b. DATE THEREOF MARCH 1, 1966		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City, town or county) (State) WASHINGTON - D.C.		
24. FUNERAL DIRECTOR Charles Judge ADDRESS Falston Md			25a. REC'D BY REGISTRAR 2 DATE 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 13
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federal Point - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>P.F.D. #2, Box 100</u>	
3. NAME OF DECEASED (Type or print) <u>Blair James</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1910</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland Plastic, Inc.</u>	
11. BIRTHPLACE (State or foreign country) <u>Irving, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Blair</u>		14. MOTHER'S MAIDEN NAME <u>Delphia E. Blair</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>226-14-0257</u>	
17. INFORMANT <u>Eldred W. Meritt, Federal Point, Md.</u>		Address <u>Federal Point, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Left ventricular Dilatation & Cardiac arrest</u> DUE TO <u>Left Ventricular</u> (b) <u>Carotid Sinus Stimulation</u> DUE TO <u>Hypertrophy</u> (c) <u>Coronary Artery Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 sec</u> <u>15 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>old Inferior Myocardial Infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Harold B. Pummer M.D.</u>		22. DATE SIGNED <u>2/22/66</u>	
EXAMINER'S NAME (Type) <u>Harold B. Pummer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>Feb. 23, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Junior Order Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Preston, Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. T. Hampton Jr.</u>		25. REC'D BY REGISTRAR <u>MAR 2 1966</u>	
ADDRESS <u>Indianapolis, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1 (M)

FOR STATE HEALTH DEPT.

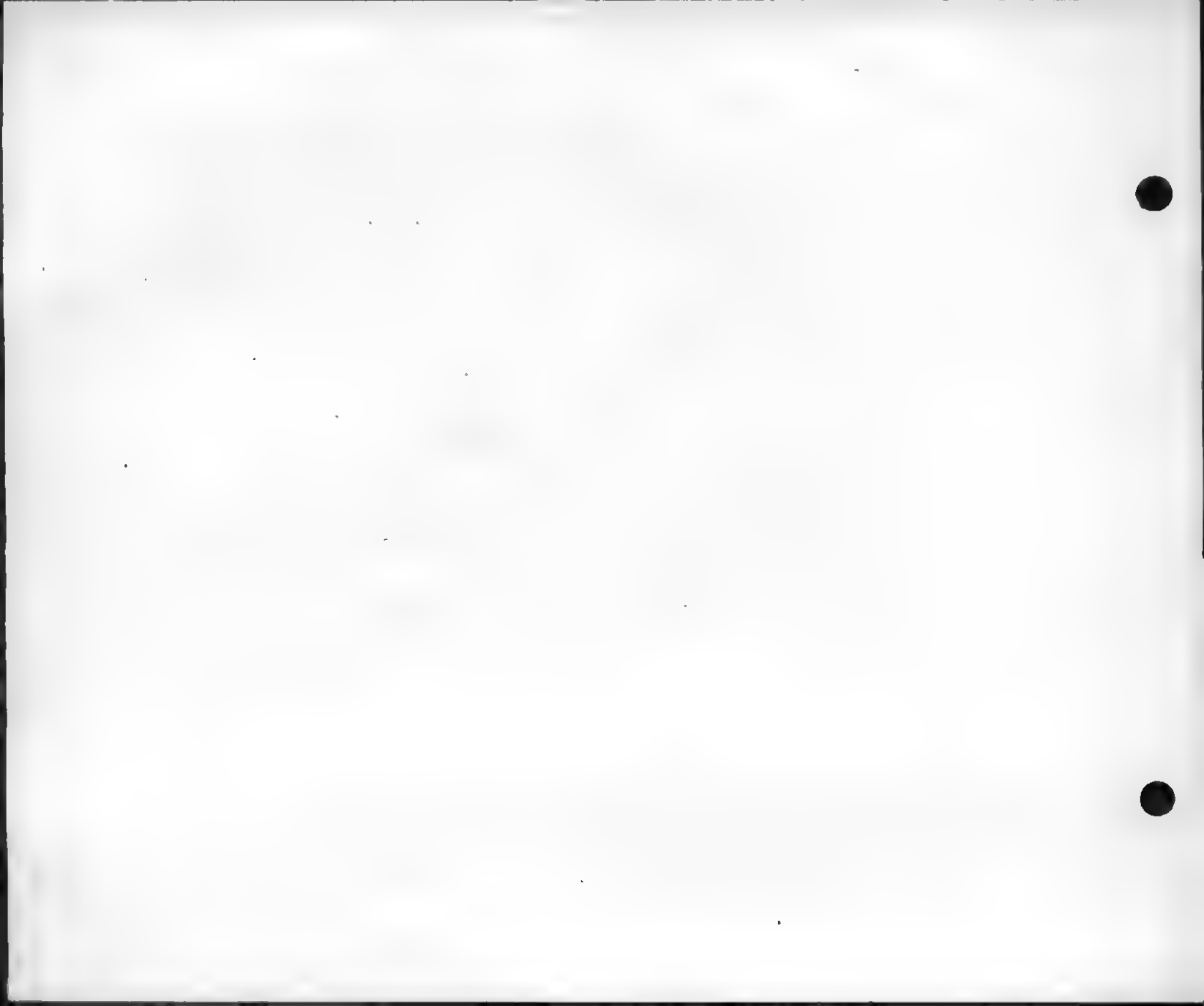
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MEDICAL CERTIFICATION

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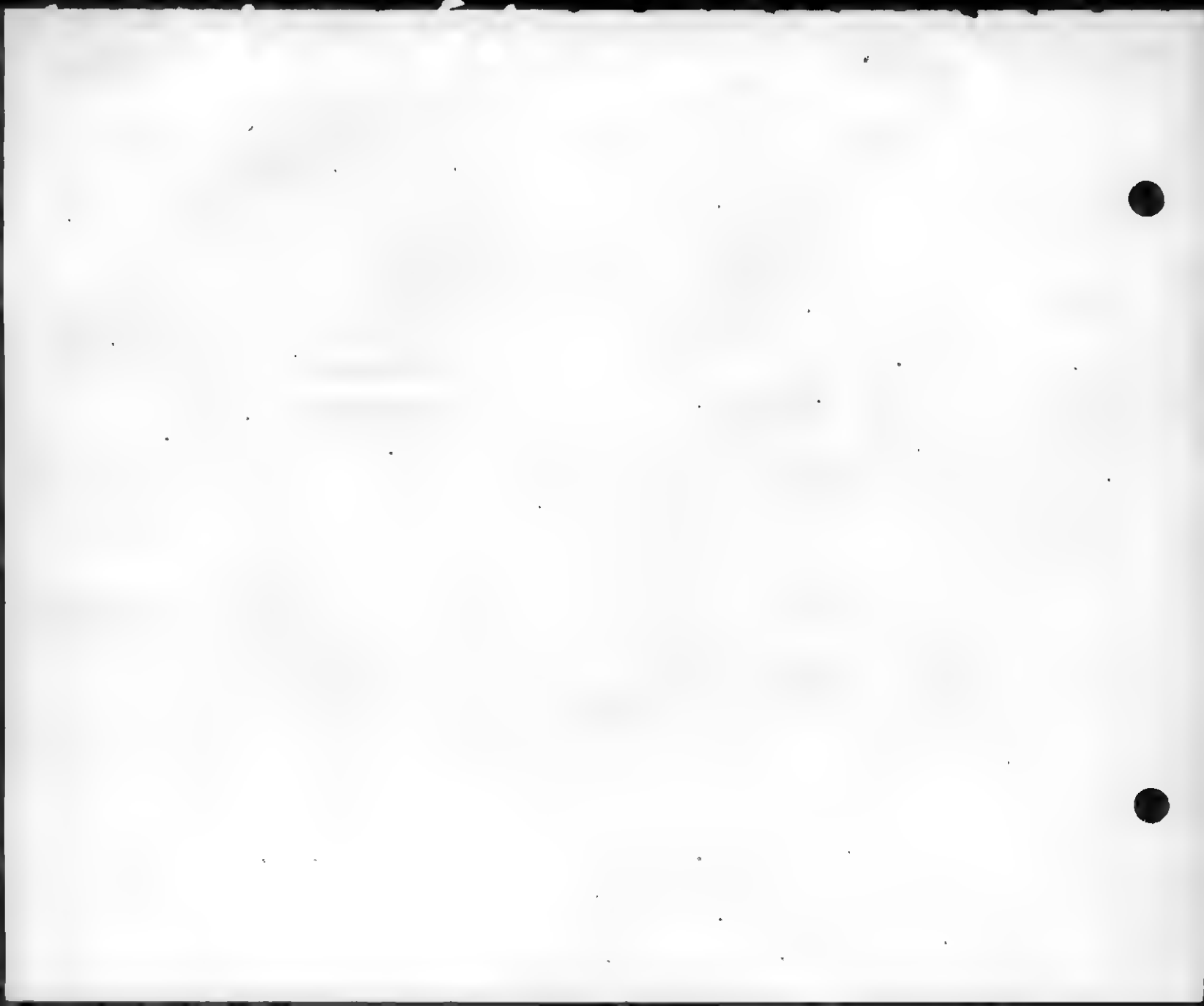


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL EASTON</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elijah Henry Nostrand</u>		4. DATE OF DEATH <u>2 - 24 - 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LIGHTING MFG</u>	11. BIRTHPLACE (County & State, or foreign country) <u>JAMICA, LONG ISLAND NY</u>
13. FATHER'S NAME <u>FRANK NOSTRAND</u>		14. MOTHER'S MAIDEN NAME <u>GEORGIANNA HURST</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-20-0680</u>	
17. INFORMANT <u>MRS IDA M. NOSTRAND</u>		Address <u>RD, EASTON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic vascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>my year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>18 Feb</u> , 19 <u>66</u> , to <u>24 Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>23 Feb</u> , 19 <u>66</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u>		22b. DATE SIGNED <u>2-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-26-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cleford</u>	23d. LOCATION (City, town or county) (State) <u>Cleford</u> <u>MD</u>
24. FUNERAL DIRECTOR <u>W. A. Clark</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 28 1966</u>	

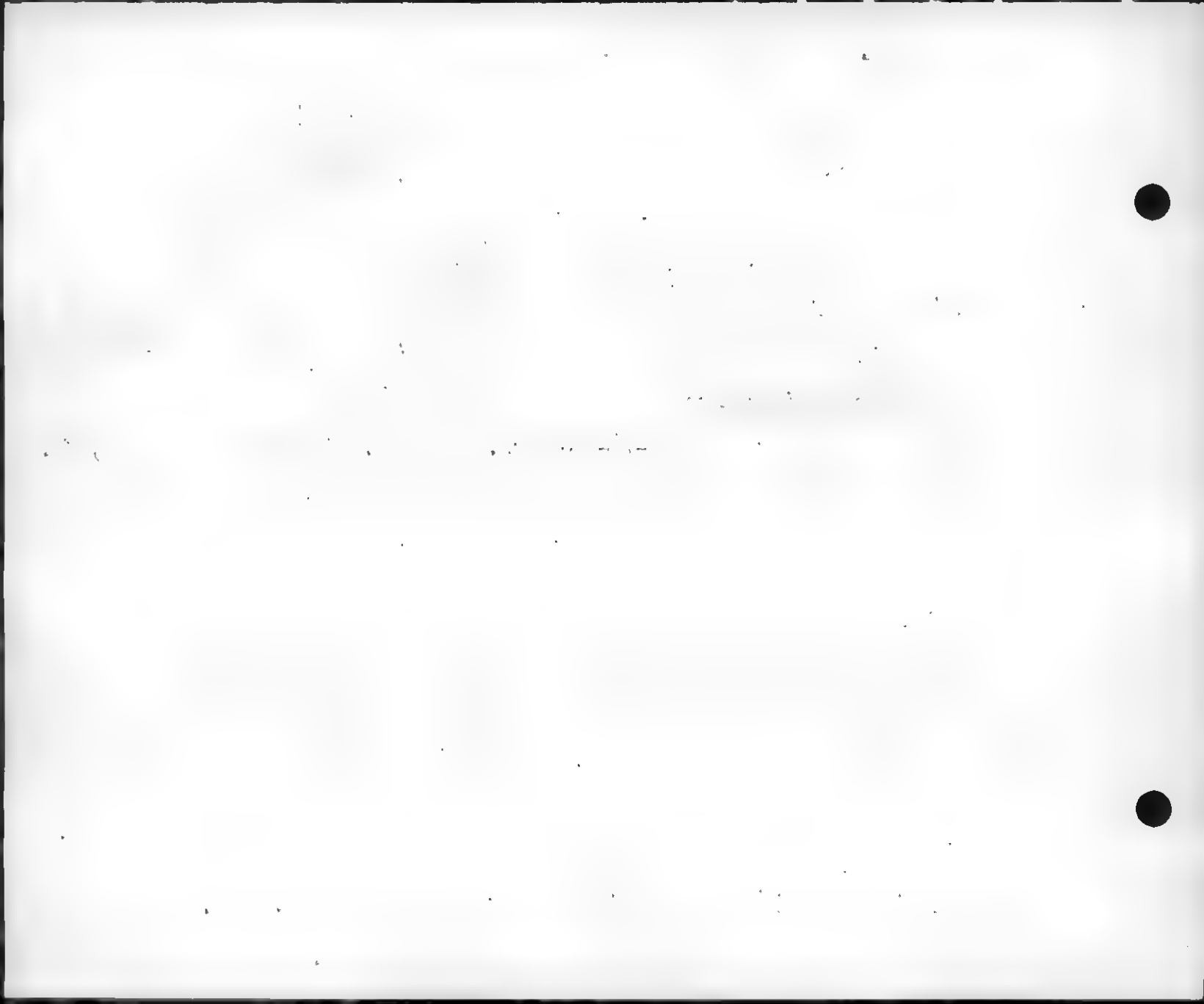


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>54A</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u> d. STREET ADDRESS <u>20-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Augustine</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1903</u>
9. AGE (in years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jabe Edward Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Truitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-14-4783</u>	
17. INFORMANT <u>Mrs. Edward A. Richardson, Tilghman, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4221 DUE TO (b) <u>atherosclerosis CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>pneumonia - Terminal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>65</u> to <u>2-1</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2-1</u> , 19 <u>66</u> and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. M. Reeser</u> M.D.		22b. DATE SIGNED <u>2-2-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. M. Reeser</u>		22d. ADDRESS <u>1000 E. Main St. Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/4/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park</u>	23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR <u>Lawrence L. Newman & Son</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 7 1966</u>			



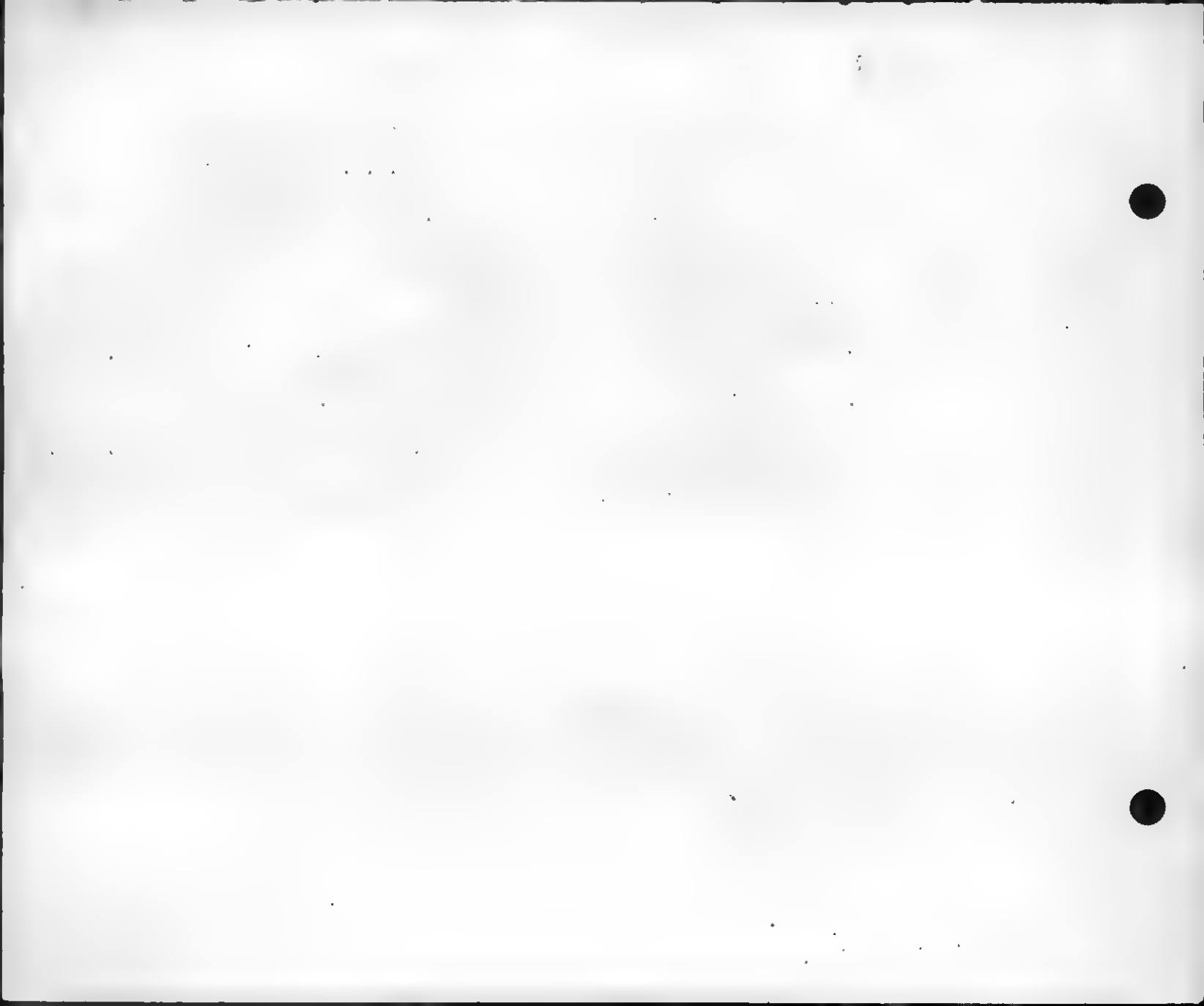
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

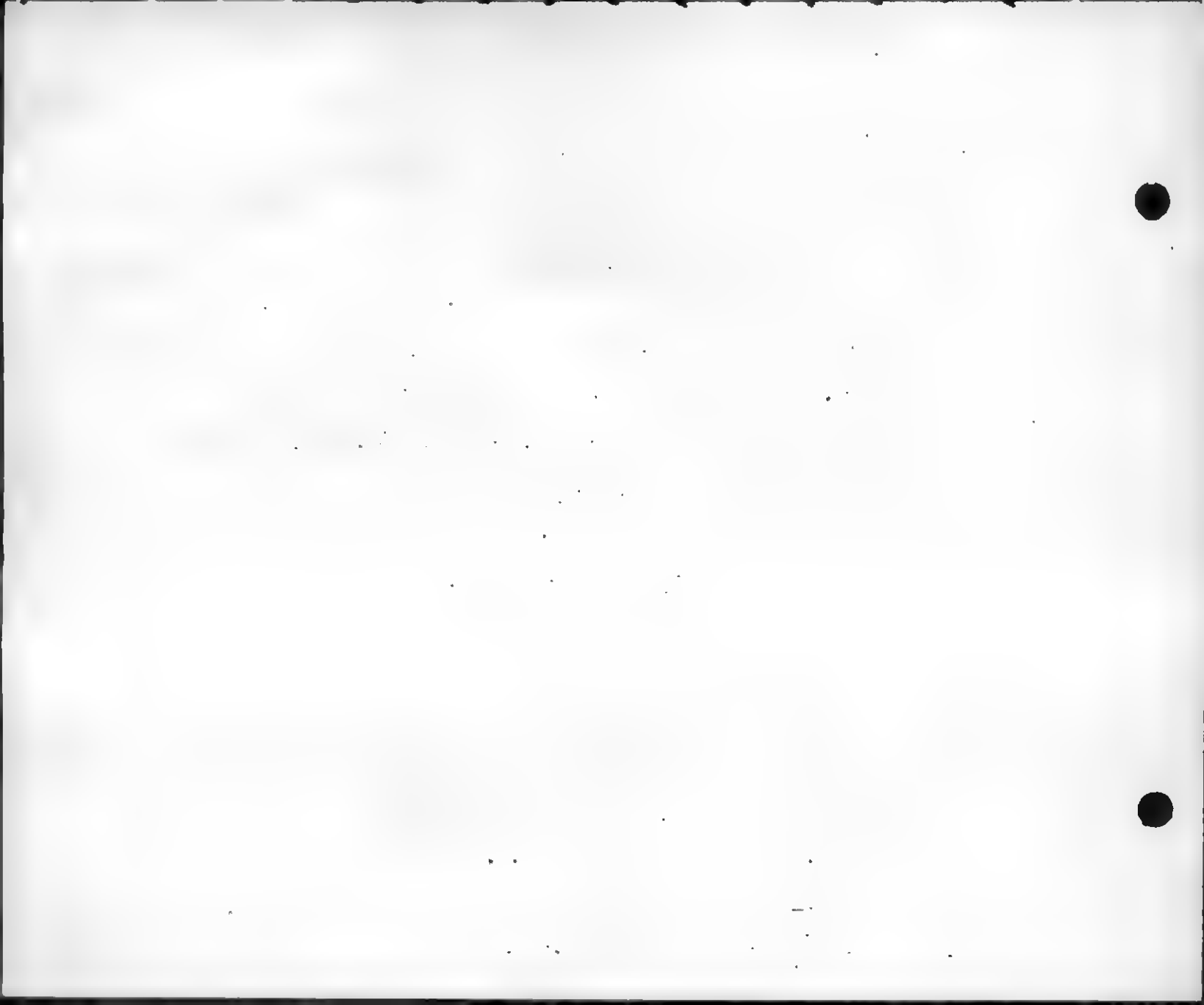
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>F.D. Federalburg</u> d. STREET ADDRESS <u>R.F.D. # 1 - Box 210</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mrs. Lydia Mae Rogers</u> First Middle Last						4. DATE OF DEATH <u>2</u> <u>21</u> <u>1966</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 7, 1907</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester County, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>E. Lee Morris</u>						14. MOTHER'S MAIDEN NAME <u>Bertha E. Wheatley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Willert P. Rogers, Federalburg, Md. R.F.D.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic renal cell carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>8 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>29 Dec</u> , 19 <u>65</u> , to <u>21 Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>21 Feb</u> , 19 <u>66</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Thurston Harrison</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>22 Feb 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>						22d. ADDRESS <u>Easton, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>February 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>			23d. LOCATION (City, town or county) (State) <u>Federalburg, Maryland</u>		
24. FUNERAL DIRECTOR <u>Frome, Raup, & Co., Federalburg, Maryland</u>						25a. REC'D BY REGISTRAR <u>FEB 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

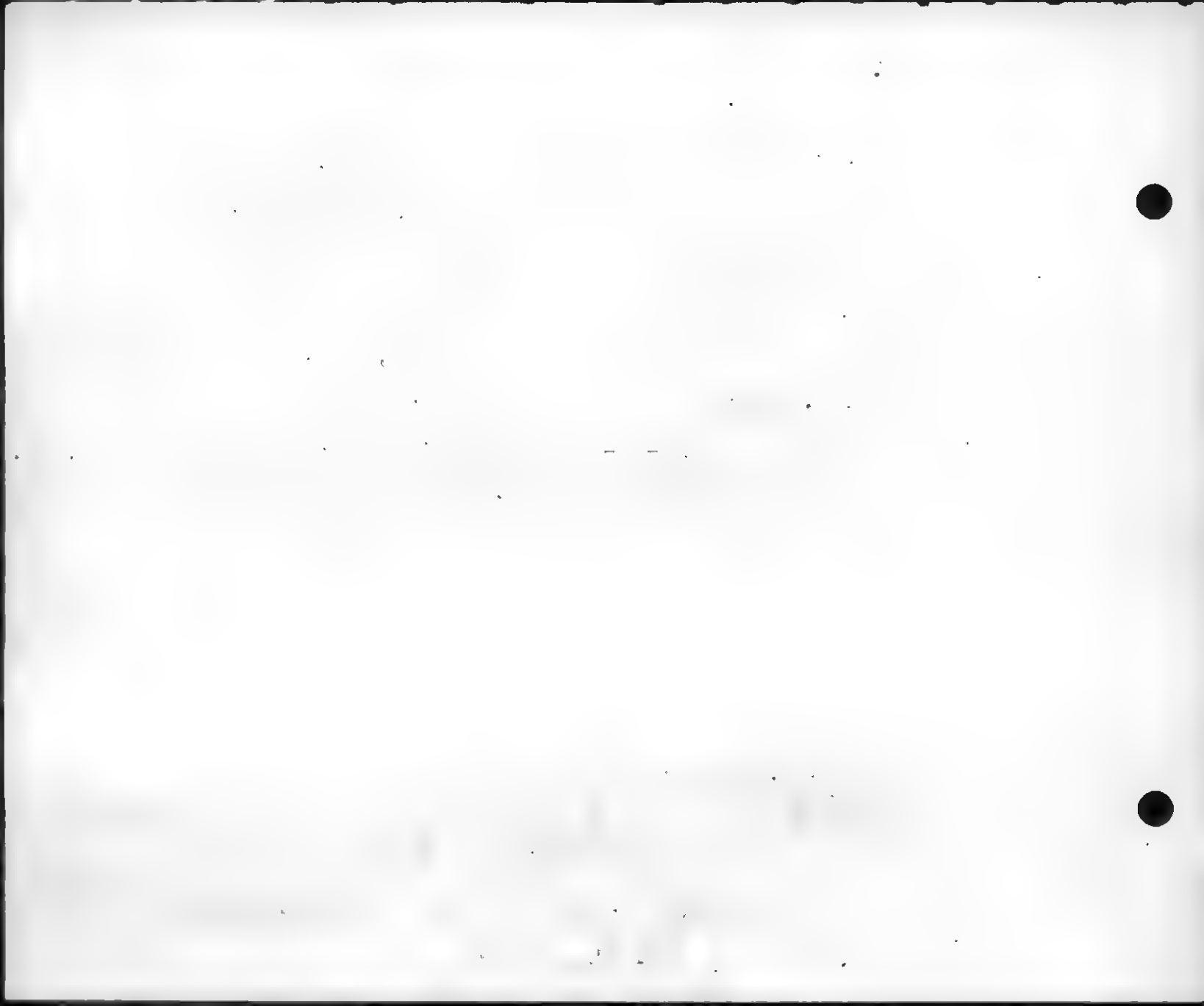
<p align="center"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </p>									
<p>02883</p>					<p align="right">02561</p>				
<p>1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u></p>				
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u></p>					<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u></p>				
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u></p>					<p>d. STREET ADDRESS <u>None</u></p>				
<p>3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Marion</u> Last <u>Ross</u></p>					<p>4. DATE OF DEATH Month <u>2</u> - Day <u>15</u> Year <u>1966</u></p>				
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Jan. 11, 1911</u></p>		<p>9. AGE (In years last birthday) <u>55</u> yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>None</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>			
<p>13. FATHER'S NAME <u>James E. Ross</u></p>					<p>14. MOTHER'S MAIDEN NAME <u>Katie Ireland</u></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u></p>					<p>16. SOCIAL SECURITY NO. <u>Unknown</u></p>		<p>17. INFORMANT <u>Mary Cole Ridgely, Maryland</u></p>		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic valvular heart disease, inactive</u> (c) <u>and Chronic cor pulmonale due to emphysema</u></p>									<p>INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>									<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>					<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>				
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>			<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>		
<p>21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u>, that (I) (we) last saw the deceased alive on <u>19</u>, and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE <u>Robert W. Trever</u></p>					<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>		<p>22b. DATE SIGNED <u>2/15/66</u></p>		
<p>22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u></p>					<p>22d. ADDRESS <u>M.D. Easton, Maryland</u></p>				
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>			<p>23b. DATE THEREOF <u>2-18-66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Ridgely</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Ridgely, Maryland</u></p>		
<p>24. FUNERAL DIRECTOR <u>John E. Boulaie Greenaloe</u></p>					<p>25a. REC'D BY REGISTRAR <u>FEB 18 1966</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>		



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02284		02562							
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Talbot				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON, MD.			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 322 North Washington			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Marion First Middle Last					4. DATE OF DEATH Month 2 Day 2 Year 1966				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/1908		9. AGE (in years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY retail		11. BIRTHPLACE (County & State, or foreign country) Talbot, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Walter D. Sharp					14. MOTHER'S MAIDEN NAME Grace Roe				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1					16. SOCIAL SECURITY NO. 216-03-7418		17. INFORMANT Katherine Marshall Sharp Easton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1966 to 1966 , that (I) (we) last saw the deceased alive on Feb 6, 1966 , and that death occurred at 6:10 P.M. from the causes and on the date stated above. 22a. SIGNATURE F. L. H. Schmidt M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED 2 Feb 66 22c. PHYSICIAN'S NAME (Type) F. L. H. Schmidt 22d. ADDRESS Easton, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB 6, 1966		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) CAMBRIDGE Md.			
24. FUNERAL DIRECTOR Jay D. Heverin, Easton, Md.					25a. REC'D BY REGISTRAR Charles J. Jago		25b. REGISTRAR'S SIGNATURE Charles J. Jago		

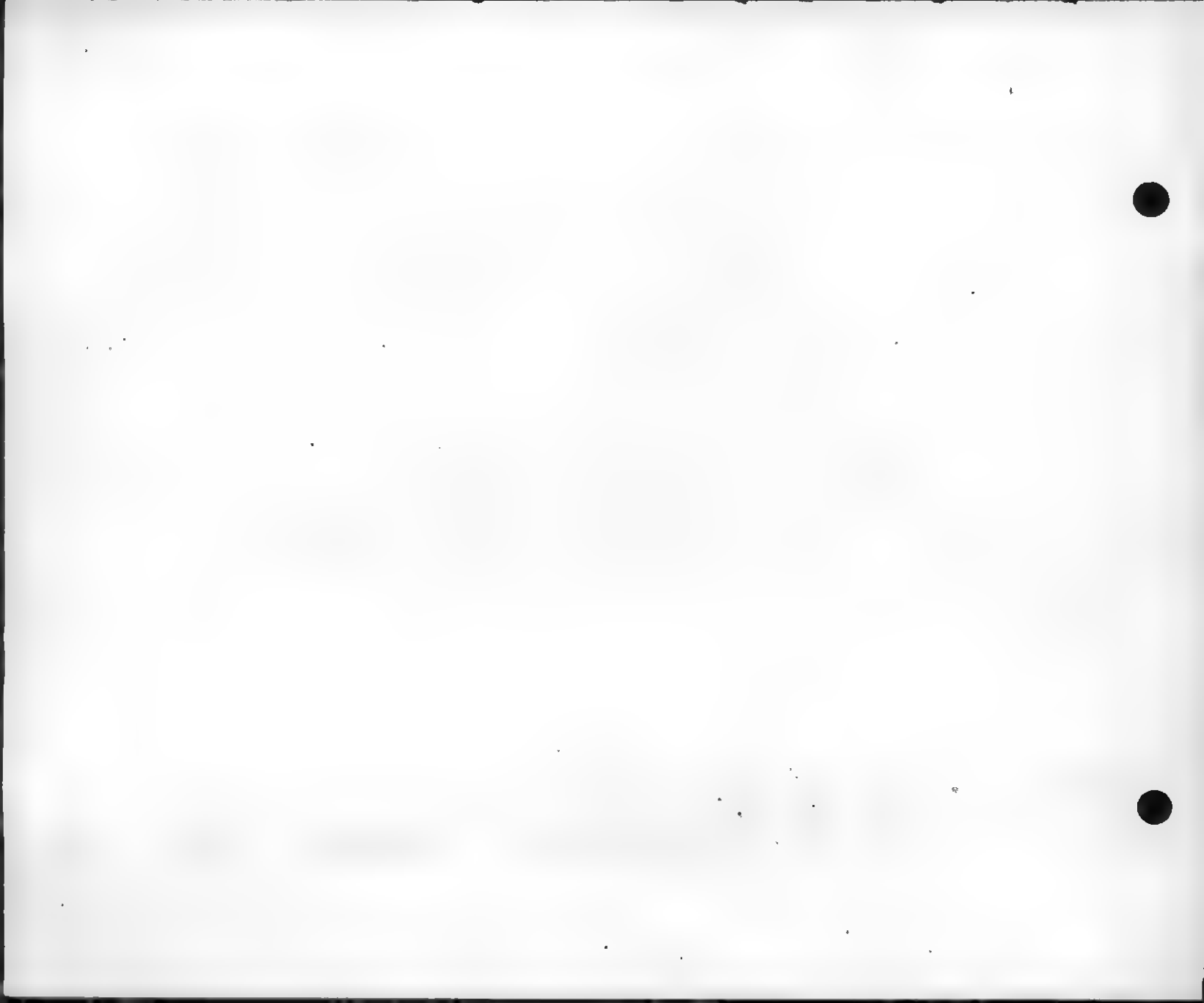


NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02285					02863					
1. PLACE OF DEATH a. COUNTY <u>Talbot</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>					
c. LENGTH OF STAY IN 1b <u>5 da.</u>					d. STREET ADDRESS <u>09-2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Rebecca A.</u> Middle <u>Summers</u> Last <u>Summers</u>					4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10, 1922</u>		9. AGE (In years last birthday) <u>44</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
13. FATHER'S NAME <u>Asbury Samuel</u>					14. MOTHER'S MAIDEN NAME <u>Della Samuel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>240-20-7066</u>		17. INFORMANT <u>Rebecca A. Summers, Hurlock, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart - cardiac</u> DUE TO (b) <u>Typhus myxomatosa</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>1966</u> and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>[Signature]</u>					22b. DATE SIGNED <u>9 Feb 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>					22d. ADDRESS <u>Easton Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>2-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>The Mount Vernon Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Near Easton, Maryland</u>	
24. FUNERAL DIRECTOR <u>Trampton Funeral Home</u>					ADDRESS <u>Federal City, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

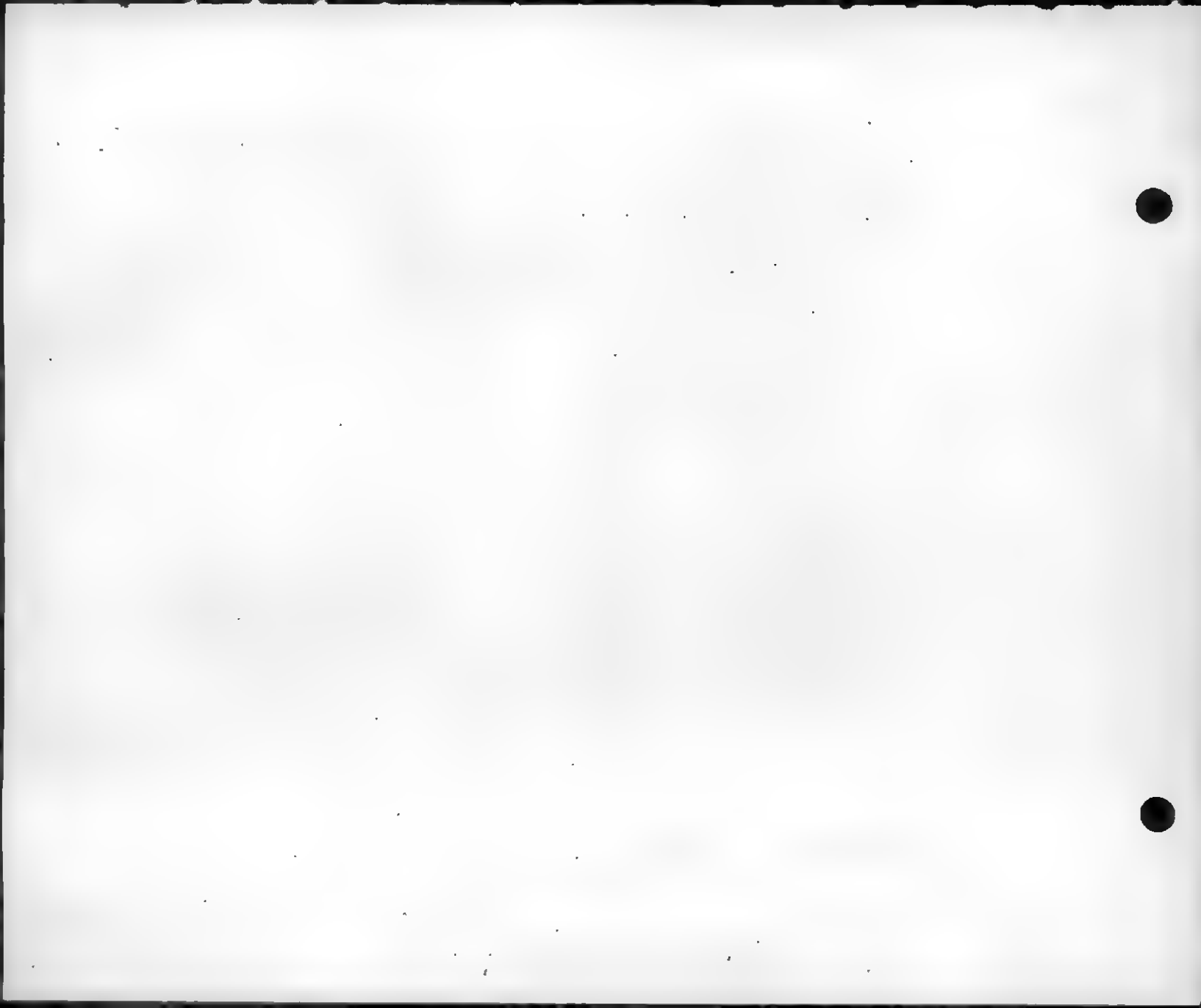
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02886

02864

1. PLACE OF DEATH a. COUNTY <u>1A1DOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rt 2 Box 238</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>-1</u>			
3. NAME OF DECEASED (Type or print) First <u>MARK</u> Middle <u>DANA</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/64</u>	9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u> Hours <u>38</u> Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT L. THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>GENEVIEVE B. WEBB</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Genevieve B. Webb, Easton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-26</u> , 19 <u>66</u> , to <u>2-26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-26</u> , 19 <u>66</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John E. Baybutt</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John E. Baybutt MD</u>				22d. ADDRESS <u>205 Earle Ave Easton, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-3-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trappe Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Trappe Maryland</u>	
24. FUNERAL DIRECTOR <u>James B. Dashiell Easton Md</u>				25a. REC'D BY REGISTRAR <u>MAR 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02887

02865

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) St MICHAELS RD c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE md b. COUNTY TALBOT c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) St Michaels RD d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle TRADER Last 4. DATE OF DEATH Month FEB Day 18 Year 1966		5. SEX M 6. COLOR OR RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Jan 4 1908 9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Salisbury md 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Trader 14. MOTHER'S MAIDEN NAME Edna Puff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 219-07-7200 17. INFORMANT Mildred Waters Address 845 Frank St Wilmington Del		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GSKN-head DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 2-18-66 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) rural St Michaels Talbot md (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-18-66 Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried 22b. DATE THEREOF 2-20-66 22c. NAME OF CEMETERY OR CREMATORY St Michaels Cemetery 22d. LOCATION (City, town, or county) Parsonsburg md (State)		23. FUNERAL DIRECTOR St Michaels Funeral Home, St. Michaels md ADDRESS 24a. REC'D BY REGISTRAR FEB 23 1966 24b. REGISTRAR'S SIGNATURE J Charles Judge	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02888											
02866											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton (rural)</u>						
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>RFD # 3 Box 101</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Eloa</u> Middle <u>Mae</u> Last <u>Walters</u>					4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/16/1927</u>		9. AGE (In years last birthday) <u>38</u> yrs.			
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <u>Antrim Michigan</u>	
13. FATHER'S NAME <u>Philo Giffin Giffin</u>					14. MOTHER'S MAIDEN NAME <u>Ruth Fox</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>380-24-0261</u>		17. INFORMANT <u>J. Worth Walters, Easton, Md.</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatic Failure</u> 170X DUE TO (b) <u>Ca. Breast with bone & P.ary met.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>16 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>B. lateral adrenalectomy - 2-8-66</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10 -</u> , 19 <u>66</u> , to <u>2-11</u> , 1966, that (I) (we) last saw the deceased alive on <u>2-11</u> 19 <u>66</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2-12-66</u>											
22c. PHYSICIAN'S NAME (Type) <u>John Knud-Hansen</u> M.D. <u>Easton, Maryland</u> 2-12-66											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/14/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>			23d. LOCATION (City, town or county) (State) <u>Hillboro, Md.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Maurice C. Newman & Son Easton Md.</u>											
25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>						25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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